



# Professionalism: A Mixed-Methods Research Study

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## GLOSSARY

We present in this glossary definitions of core terms, mainly based on references used in this review. By providing a glossary, our intention is to enhance the understanding of this report rather than to establish one final 'definition' for each concept.

Adverse events	Unintended injuries or complications that are caused by the management of a patient's healthcare, rather than by the patient's underlying disease. In dentistry, an adverse event (AE) is defined as "unnecessary harm due to dental treatment".
Altruism	The principle or practice of unselfish concern for the welfare of others. A more realistic concept is "to balance availability to others with care for oneself."
Association for Dental Education in Europe (ADEE)	A European non-profit educational organisation, which brings together a broad-based membership across Europe comprised of dental schools, specialist societies and national associations concerned with dental education.
Burnout (occupational)	According to the World Health Organisation (WHO), occupational burnout is a syndrome resulting from chronic work-related stress, with symptoms characterised by "feelings of energy depletion or exhaustion; increased mental distance from one's job or feelings of negativism or cynicism related to one's job; and reduced professional efficacy." The instrument for assessing burnout is the Maslach Burnout Inventory (MBI), which assesses the 3 dimensions of the burnout, namely emotional exhaustion, depersonalisation, and reduced personal accomplishment.
Competence / Competent	Professional behaviours and skills required by a graduating dentist in order to respond to the full range of circumstances encountered in general professional practice. Professional competence has also been defined as 'the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.'  'Competent' is defined in the GDC documents as 'having a sound theoretical knowledge and understanding of the subject together with an adequate clinical experience to be able to resolve clinical problems encountered, independently, or without assistance'.
Continuing Professional Development (CPD)	The systematic maintenance, improvement and continuous acquisition and/or reinforcement of the lifelong knowledge, skills and competences of health professionals. It is pivotal to meeting patient, health service delivery and individual professional learning needs. The term may include procedural, scientific, regulatory and ethical developments, as well as research, management, administration and patient-relationship skills.
Continuing Professional Development (CPD) for dental professionals	Learning, training or other developmental activities, which can reasonably be expected to maintain and develop a person's practice as a dentist or dental care professional and is relevant to the person's field of practice.

Cultural competence	Congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural acquisition. The goal of cultural competence in the health professions is to create health care systems and workforces that are proficient at delivering high quality care to every patient regardless of race, ethnicity, culture, gender, or language.
Delphi process/ method/technique	The <i>Delphi technique</i> is named after the Ancient Greek oracle of Delphi, who could predict the future. It is a systematic interactive way of congregating expert opinion through a series of iterative questionnaires, with a goal of coming to a group consensus. Several rounds of questionnaires are sent out to the group of experts (who may be experts from experience of services), and the anonymous responses are aggregated and shared with the group after each round. Thus, experts are encouraged to revise their earlier answers considering the replies of other members of their panel. It is believed that during this process the group will converge towards an answer. The process is stopped after a predefined stop criterion (e.g., number of rounds, achievement of consensus, stability of results). The characteristic features of the Delphi are anonymity, iteration with controlled feedback, statistical group response, and expert input.
Dental Care Professionals (DCPs)	The oral health professionals supporting a dentist and working as a team: dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.
Dental foundation training	In UK, newly qualified dental graduates spend a mentored year in general dental practice settings under a scheme known as foundation training. Formerly known as Vocational training (VT), foundation training was initially started as a voluntary scheme for new dental graduates in UK as early as 1977. However, in 1993 a one-year period of training subsequently became a mandatory requirement for all newly qualified dental graduates in UK who intended to practice within the National Health Service. This arrangement 'allows a gradual and controlled transition from the shelter of undergraduate education to unsupervised practice'.
E-learning/online learning	A comprehensive concept that refers to learning facilitated and supported through the use of information and communication technologies. The broad concept of e-learning includes a range of educational methodologies, from entirely online learning to technology-assisted learning and blended learning.
Empowerment	Empowerment has been defined as a social process of recognising, promoting and enhancing people's ability to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their own lives.
EndNote	A reference management software package, used to manage bibliographies, citations and references. References retrieved from all databases (Medline, CINAHL, Ovid, Web of Science etc) were imported into Endnote, which enabled the researchers to efficiently manage the screening process.

Evidence-based practice (EBP)	The conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It integrates three principles: (1) the best available research evidence on the specific clinical problem, (2) clinical expertise of the health professional, and (3) patient's values, preferences and expectations. It started in 1992 in the field of medicine (evidence-based medicine).
Feedback  Relevant: 360° feedback (Multi source feedback or MSF)	<p>In clinical settings, feedback refers to the specific information about the comparison between a professional's observed performance and a standard, given with the intent to improve the professional's performance.</p> <p>A questionnaire-based method of assessing an individual in which multiple respondents (assessors), representing discrete professional groups, provide confidential feedback on key performance behaviours. In healthcare professions, the assessors' groups may include doctors, dentists, patients, co-workers, allied health professionals (nurses, pharmacists), clerical and managerial staff.</p>
Fitness to practise	Fitness to practise implies that health professionals continue to practice in accordance with regulators' standards, including requirements relating to the maintenance of professional skills and knowledge. It encompasses an assessment of both conduct and competence.
Focus Group	A form of qualitative research, where the researcher poses questions (related to the issue being studied) which are discussed with a group of people, providing the researcher with in-depth knowledge concerning attitudes, perceptions, beliefs and opinions of individuals regarding the topic. During this process, the researcher either takes notes or records the discussion.
General Dental Council (GDC)	The UK-wide statutory regulator of just over 100,000 members of the dental team, including approximately 40,000 dentists and 60,000 dental care professionals. Their primary purpose is to protect patient safety and maintain public confidence in dental services. To achieve this, they register qualified dental professionals, set standards for the dental team, investigate complaints about dental professionals' fitness to practise, and work to ensure the quality of dental education.
Grades of quality (grades of evidence)	A system for grading the quality of evidence for outcomes reported in research studies. Systematic reviews and randomised controls trials are rated high in the quality scale, whereas case reports and opinion papers are usually rated as low-quality evidence. Limitations in the design and implementation of the study, inconsistency or imprecision of results, high probability of bias are among the factors lowering the quality of the study.
Grey literature	This refers to materials and research produced by organisations outside of the traditional academic publishing and distribution channels. Common grey literature publication types include reports (annual, research, technical, project, etc.), working papers, government documents, white papers.

Hidden curriculum	The attitudes and values conveyed, often in an implicit and tacit fashion, albeit unintentionally, via the educational framework, practices and culture of an educational institution, which fall outside the formal curriculum. The concept of a “hidden curriculum” is an emerging area of research as it plays a critical role in the development of the emotional and behavioural outlook of a future clinician.
Interprofessional education (interdisciplinary education)	Refers to an educational situation, where members of two or more professions are engaged in learning with, from and about each other. It aims to improve relationships, increase trust and deepen understanding of other professionals’ roles and responsibilities and assist in the development of communication and interpersonal skills.
Lifelong learning	All general education, vocational education and training, non-formal education and informal learning undertaken throughout life, resulting in an improvement in knowledge, skills and competences. Such learning might occur within a personal, civic, social and/or employment-related perspective.
Literature review	A comprehensive summary of previous research on a topic. The literature review surveys scholarly articles, books, and other sources relevant to a particular area of research. The review should enumerate, describe, summarise and critically evaluate the previous research on a topic, with the aim to identify strengths, gaps, controversies or areas for further research and not merely provide summaries or descriptive lists.
Mentor/mentoring	Traditionally, a person who teaches or gives help and advice to a less experienced person, the ‘mentee’. Traditional mentoring is a hierarchical relationship in which the more experienced person provides guidance over a sustained period of time to a less experienced ‘mentee’, tailored to the expertise of the mentor and the needs of the ‘mentee’. Modern mentoring is a cooperative, mutually beneficial process, whereby the mentor participates in the mentee’s professional development, by providing learning, advice, guidance and encouraging.
Mixed methods research	A method that uses multiple sources of data collection with the aim to provide a better understanding of research problems than an individual data source alone, and to subsequently increase the pragmatic validity through triangulation. It focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies.
National Health Service (NHS)	The publicly funded healthcare system of the United Kingdom, established in 1948 as one of the major social reforms following the Second World War. The founding principles were that services should be comprehensive, universal and free at the point of delivery.
Objective Structured Clinical Examination (OSCE)	A form of performance-based examination, used to assess clinical competencies in a range of skills, mainly in clinical sciences. It is a hands-on, real-life approach to learning and assessment, with standardised content and grading, and also repeatable and reliable. It includes a number of ‘stations’, each one presenting a clinical problem, through which the assessed individual rotates, while being observed and evaluated.
Outcomes-based curriculum	A learner-centred approach to education that focuses on what a student should know, understand and be able to do upon completion of the program. The curriculum is constructed by first determining the <i>learning</i>

	<i>outcomes</i> (statements of the skills, knowledge and attitudes the learner will “own” at the end of the course). The process ensures that the learners can demonstrate achievement of outcomes, and that learning outcomes, learning activities/methods and assessment are aligned.
Outreach training/ education	Structured training / education which takes place outside the premises of the academic institution, e.g. in community settings, healthcare facilities, hospitals, rural practices, etc. and offers the opportunity to learners to practice in the ‘real world’, outside the protective environment of the University.
Patient safety	The prevention of errors and adverse effects to patients associated with health care (World Health Organisation, 2016).
Related: Patient safety incidents	Any unintended events or hazardous conditions resulting from the process of care, rather than due to the patient's underlying disease, that led or could have led to unintended health consequences for the patient or health care processes associated with safety outcomes.
Peer review	A critical examination and evaluation of the performance of individual health professionals by members of the same profession or a team. It may be formal or informal.
Portfolio	A professional tool for collecting evidence of both the processes and product of learning. It encourages practitioners to engage in critical reflection on their accomplishments and current practices, gain insight into their strengths, weaknesses and learning needs, and perform prospective analysis to guide their future development.
Preparedness for practice	Being capable of carrying out patient assessment and treatment planning, perform routine, straightforward dental procedures safely, provide holistic care, communicate effectively, demonstrate professionalism and team-working skills, recognise own limits and know when to seek help. The concept of ‘preparedness’ can be problematic, with the term being related to clinical or technical performance, competence and/or confidence, depending on the understanding and opinions of the stakeholder being asked.
PRISMA guidelines	The PRISMA (Preferred Reporting Items for Systematic Review and Meta-analysis) guidelines is the proper methodology for conducting and reporting a systematic review. Full compliance with the guidelines will clearly and justifiably indicate inclusion and exclusion criteria, facilitate clarity and transparency in reporting, enable a structured report and synthesise the findings of the eligible studies.
Problem-based learning (PBL)	An educational method (derived from andragogy – adult learning theory) in which students are presented with real-life problems that stimulate them to discuss, reflect, negotiate and evaluate. Student responsibility and self-directed learning are emphasised, and teamwork skills are also nurtured. Teaching strategies include critical thinking questions, scenarios, case studies and small group work.

Professionalism	Professionalism is described as demonstrating a commitment to patients, society, the profession, and self (self-awareness and well-being). Professionalism is a second order competence, complex and multifaceted.
E-professionalism	Behaviour related to professional standards and ethics when using electronic communications.
Purposive sample	A purposive sample, also known as judgmental, selective, or subjective sample, is a non-probability sample that is selected based on characteristics of a population that are of interest and the objective of the study. Purposive sampling relies on the judgement of the researcher while selecting the members of population to participate in the study. The sample being studied is not representative of the population, thus generalisations cannot be made, but for researchers pursuing qualitative or mixed methods research designs, this is not considered a weakness.
Qualitative study /research	It is an exploratory research method, used to gain an understanding of underlying reasons, opinions, experiences, attitudes, behavior and interactions. It generates non-numerical data. Qualitative data collection methods vary using unstructured or semi-structured techniques. Some common methods include focus groups (group discussions), individual interviews, and participation/observations.
Rapid Evidence Assessment (REA)	An approach to evidence review which uses the same methods and principles as a systematic review but makes concessions to the breadth or depth of the process, in order to synthesise evidence and produce results within a shorter timeframe than that required for a full systematic review. It may use a combination of key informant interviews and targeted literature searches to provide a balanced assessment of what is already known about a specific problem or issue. It is particularly helpful in informing policy and decision makers, program managers and researchers.
Rapid review	A form of evidence synthesis that may provide more timely information for decision making compared with systematic reviews. A rapid review speeds up the systematic review process by simplifying or omitting stages of the systematic review to produce information in a short period of time.
Reflection	A metacognitive process that creates understanding of specific issues in practice through critically contextualising, observing and analysing, to generate new knowledge and insights which can enhance practice.
Related: Reflective practice	An active and deliberate process of critically examining one's practice in which the individual is challenged to engage in self-assessment, leading to new understanding and development of new knowledge.
Remediation	An intervention or a range of interventions required in response to assessment against a threshold standard of performance. Remediation interventions are based around a three-step model that involves the identification of a performance deficit, the implementation of a remediation intervention and retesting after the intervention.
Role model	A person whose behaviour, example, or success is or can be emulated by others. Role modelling in education refers to a process where faculty members demonstrate clinical skills, model and articulate expert thought processes, and manifest positive professional characteristics.

Semi-structured interviews	In-depth interviews, commonly used in qualitative research, where the respondents have to answer pre-set open-ended questions. It is the most frequent qualitative data source in health services research. The method consists of a dialogue between researcher and participant, guided by a flexible interview protocol and supplemented by follow-up questions, probes and comments.
Scoping interview	In the initial phase of a qualitative research, an interview with a group of individuals - subject experts, aiming at identifying the key themes of the subject, clarifying concepts and assumptions, eliciting sources, and in general establish the theoretical framework of the research.
Self-assessment	Involvement of learners in making conclusions about their own learning, particularly about their achievements and the outcomes of their learning, in relation to identified standards/ learning outcomes.
Social media	<p>Digital technologies that enable individuals and communities to gather, communicate, interact, share (information, ideas, career interests) and in some cases collaborate or play.</p> <p>The GDC defines social media as follows: 'Social media covers a number of internet-based tools including, but not limited to, blogs, internet forums, content communities and social networking sites such as Twitter, YouTube, Facebook, LinkedIn, GDUK, Instagram and Pinterest. Professional social networking websites aimed solely at dental professionals are also forms of social media.'</p>
Soft skills	A cluster of productive personality traits that characterise one's relationships in a milieu. They are a combination of people skills, social skills, communication skills, character or personality traits, attitudes, social intelligence and emotional intelligence quotients, that enable people to navigate their environment, work well with others, perform well, and achieve their goals with complementing hard skills (also known as technical skills).
Systematic review	An approach to literature review designed to provide an objective, complete and exhaustive summary of current evidence relevant to a research question. It involves a detailed and comprehensive plan and search strategy derived a priori, with the goal of reducing bias by identifying, critically appraising, and synthesising findings qualitatively or quantitatively.
Workplace-based assessment (WBA)	The assessment of the trainee's professional skills and attitudes, which provides evidence of appropriate clinical competences. Direct Observation of Procedural Skills (DOPS), Mini-Clinical Evaluation Exercise (mini-CEX), Objective Structured Clinical Examinations (OSCEs) and Case-based discussion (CbD) are commonly used methods of workplace-based assessment.
Work shadowing	A reciprocal learning process whereby a person 'shadows'/ follows or observes a professional in their work role for a period, for the purpose of enhancing their knowledge, skills and understanding. It is a beneficial learning experience for both parties.

## Abbreviations

ADEE	Association for Dental Education in Europe
AI	Artificial Intelligence
BDA	British Dental Association
CDO	Chief Dental Officer
COPDEND (UK)	Committee of Postgraduate Deans and Dental Directors (UK)
CPD	Continuing Professional Development
DCP	Dental Care Professional
ERG	Expert Reference Group
FD	Foundation Dentist
FT	Foundation Trainer
FtP	Fitness to Practise
GDC	General Dental Council
GDP	General Dental Practitioner
GMC	General Medical Council
GP	General Practitioner
NHS	National Health Service
PASS	Professional Advice Support and Sharing
PRB (GDC)	Policy and Research Board (GDC)
REA	Rapid Evidence Assessment
UDA	Units of Dental Activity



## EXECUTIVE SUMMARY

The General Dental Council (GDC) seeks to ensure that its work and policies are informed by current evidence. To support the delivery of the commitments made in their corporate strategy (2019), the GDC commissioned this review, undertaken by a project team under the auspices of the Association for Dental Education in Europe (ADEE).

### Aims

The review aimed to address the following research questions:

1. What aspects of professionalism does the public expect from dental professionals (what causes a patient to lose trust), and why are these perceived as important?
2. How can aspects of professionalism be categorised (e.g. moral, clinical, personal behavioural, in work, outside work)?
3. Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals?
4. The teaching of professionalism - how does the undergraduate curriculum prepare students to meet professionalism expectations and how this is evidenced?

### Methods

A mixed-methods approach was followed comprising scoping interviews with 13 topic experts, a rapid evidence assessment (REA) of professionalism literature (92 publications), nine focus groups with dental professionals and members of the public (five focus groups with dentists, one with dental care professionals (DCPs) and three with members of the public), and a modified Delphi process<sup>1</sup> to seek a consensus on 53 professionalism behaviours (665 individuals responded to the two rounds of the survey). Additional contributions to this review came from co-production events organised by the GDC. Research ethics approval was obtained from Cardiff University (SREC#3389).

### Key Findings from the Review of Professionalism

After highlighting an overview of key points, we summarise findings in relation to the four research questions. We then draw attention to the implications raised by this review of professionalism. The full report provides the detail on which this summary is based.

### Overview

- The public talked about professionalism in terms of safety: knowing the treatment risks and being treated by a practitioner with 'safe' hands. For many dental professionals, clinical competence was an assumed aspect or pre-requisite for professionalism.
- The distinction between working life and personal life is important. Although both members of the public and dental professionals highlighted the ethical relevance of behaviour and attitudes in a professional's personal life, patients took a more lenient approach.

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<sup>1</sup> The Delphi process has the goal of reaching a group consensus through a series of iterative questionnaires. The responses are aggregated and shared with the group after each round. Thus, respondents revise their earlier answers in the light of the aggregated responses of others and the group converges towards an agreed response.

- Good communication is paramount to all concerned. The public expect clear explanations, engagement in the decision-making process, being put at ease, made aware of the risks and consequences, and feeling their opinions matter. They do not want to be overwhelmed or confused or told what will happen without consideration of their views.
- Communication is restricted by time-constraints and other business pressures.
- Dental professional groups discussed the tension between patient interests and financial interests, and the impact of financial pressures and isolation on professionalism.
- Social media was recognised as a risky space where inappropriate behaviours may be revealed to patients.
- There was some disparity in the expectations of professionalism across and between different members of the dental team, and patients also highlighted the importance of the role of the receptionist as their first point of contact. This links with the issue of good communication skills for all team members. Expectations of behaviour were broadly similar across all the healthcare professions.
- Professionalism is developed through observation and reflection and can be challenging to assess. New dentists learn from observing seniors. Insight and reflection were viewed as important throughout dental training and professional practice.
- Professionals need guidance in cultural differences, differences in workplace environments and patient cohorts.
- Communication to support patients to make better informed decisions was seen as a priority. Suggestions include:
  - educating the public about what it is reasonable to expect of a dental professional.
  - events with the public about how concerns can be best addressed.
  - positively engaging with complaints and concerns.
  - clarity for patients and professionals of the standards that drive fitness to practise outcomes.

**Research Question 1: What aspects of professionalism does the public expect from dental professionals and why are these important?**

*a) Key Messages from the Scoping Interviews*

- Often interviewees found it easier to define professionalism by discussing lapses in professionalism.
- In most cases, breaches in professionalism were framed as ‘lapses’, meaning that behaviour in a particular situation may be unprofessional without implying that person is inherently unprofessional.

- There was a recognition that everyone makes mistakes, and that the important thing is to learn from them.
- To an extent, professionalism was seen as extending beyond what happens in the clinic: some interview participants expected professionals to behave in an ethical fashion when it has no impact on patients.

*b) Key Messages from the Rapid Evidence Assessment*

- Members of the public expect a consumer service from the dental team. The financial and transactional elements of dental care influence patient experience, access to care and trust. Patients expect technically good care, and, on balance, this appears to be more important to them than other aspects of professional behaviours. Dental professionals are expected to be trained to provide dentistry and to be up-to-date in their clinical practice.
- Patients expect to have their interests put first and to be involved in decision-making about their treatment and care. They expect to be treated with dignity, respect and compassion.
- These expectations are important to patients because a caring manner and good communication can lessen patient anxiety and enhance patients' assessment of the quality of the care. Involvement in decision-making helps to develop trust.
- Dental professionals focus more than patients on the technical aspects of what can and should be delivered, and aspects of teamwork.
- Barriers to professionalism operate at micro, meso and macro levels in a complex mix. Working in the best interests of patients may be challenging because of financial disincentives and pressures, unrealistic patient expectations and working environments. The quality of communication can be limited by time-constraints and patient requirements. Workplace issues identified by dental professionals include bullying and poor professional behaviours towards members of the team, but these were not issues highlighted in studies of patients.

*Gaps in the literature*

- There is little evidence explaining concepts of seriousness in terms of lapses of professional behaviours and how these are mitigated or addressed.
- There is little evidence relating to the penalties associated with lapses in professionalism or criminal conviction and what would be appropriate within specific contexts. Similarly, there is little evidence that considers approaches to addressing lapses in professionalism, for example the role of remediation.

*c) Key Messages from the Focus Groups*

- Communication was widely discussed in all groups. Good communication was considered a very important aspect of professionalism. Empathy, compassion, politeness and friendliness helped patients to feel treated as a person and making conversation was seen as instrumental in putting patients at ease. It was also highlighted that patients want clear explanations of treatment options without being overwhelmed. Examples of poor communication were described as being unclear, robotic, rude, condescending, rushed, overly familiar and not respecting

privacy. The importance of dentists building rapport and trust with patients was recognised. The public and professionals shared the view that dentists should be formal with patients at first, but may become more informal over time. The dental professional focus groups also shared potential communication challenges, for example, managing the anxious patient or a confrontational patient. Demand for cosmetic treatments (e.g. Botox) was noted as becoming more common, with potential impacts on the nature of communications between dental professionals and patients.

- Dental professional groups reported that they work in the patients' best interests but are nevertheless seen by some members of the public as focused on the business aspect of practice because of a small minority of dentists who prioritise profit. Members of the public were indeed concerned with dentists working for profit, although they did not report any stories which directly supported this. In general, the public gave very few reports of making complaints about dental professionals.
- The focus group analysis supports the idea that the public is primarily concerned with what happens in a dental appointment. The public talked about safety in terms of knowing the treatment risks and being in 'safe hands'. For parents, the experience of taking their children to the dentist was very important in forming their opinion of dental professionals. The public were concerned about practice and practitioner hygiene and cleanliness. They also wanted spaces that allowed for privacy.
- The dental professional groups were more concerned about behaviour in a professional's personal life than the public. Drinking alcohol was generally seen as less acceptable for dentists than some other professional groups, for example lawyers. There was a clear sense of the need for care (for example, avoiding excessive drinking in public and confining drinking to weekends). In contrast, drug taking was deemed more clearly unprofessional because of its illegal status. Dentists also seemed more concerned about interactions with members of the public outside of the clinic.
- Appearance and clothing were discussed more with the dental professionals than with members of the public. Dental professionals agreed that appearance matters to patients and thought that wearing a uniform, for example, creates a good impression. A shift in the perception of tattoos, piercings, and brightly coloured hair was recognised, with attitudes becoming more accepting. The patients were vaguer about their expectations, wanting a dentist to look smart, groomed, and clean.
- Social media was primarily discussed as a risky space where inappropriate behaviours may be revealed to patients. There was acknowledgement that social media is unavoidable for younger generations, but very little was said about positive uses of social media.

## **Research Question 2: How can aspects of professionalism be categorised?**

### *a) Key Messages from the Scoping Interviews*

- It was suggested that professionalism develops in challenging situations.

- Some interviewees noted that there can be a tension about the balance between patient interests and financial interests.
- Clinical competence can be viewed as a prerequisite for professionalism.

*b) Key Messages from the Rapid Evidence Assessment*

- Categorisations of professionalism were not often explicit in the literature. From our analysis of the literature, we identify three key areas of professionalism.
  - Expected service experience** which would include:
    - What is expected from the members of the dental team (and their roles).
    - Safe and clean practice.
    - Timeliness of services (getting appointments and being seen on time).
  - Interpersonal patient experiences** which focuses on the patient experience of interactions with dental professionals:
    - Communication skills, including listening, empathy, trustworthiness, conveying a sense of being treated with dignity and respect.
    - Being empowered and involved as a partner in making decisions about their own care.
    - Feeling that decisions are financially fair and are based on their own needs and not financial pressures on the dentist.
    - Being able to understand proposed treatment and the costs of dental care.
  - Professionalism in dentistry and the **personal and professional divide**:
    - Expectations of a dental professional and their behaviour in their personal life (being someone who can be trusted to make an appropriate decision).

*Gaps in the literature*

- There are considerable anxieties amongst the dental profession particularly in relation to payments and systemic pressures on practice but there is little information to indicate how these should be overcome particularly as the evidence often centres on the individual and not on the system.
- There are many areas where there is no clarity in terms of the severity of an aspect of unprofessional behaviour.

*c) Key Messages from the Focus Groups*

- For many in the dental groups, clinical competence was an assumed aspect of professionalism.
- Distinction was made between behaviour in the workplace and outside of the workplace. Members of the public were much less concerned than the dental team members about a professional's behaviour outside of the workplace. Ethics were discussed in the public groups only in relation to specific examples of morally questionable behaviour provided by group members.
- Dental professional groups discussed the impact of regulations, financial pressures, and isolation on professionalism. They presented complaints as a

serious issue facing every dentist and talked about 'defensive dentistry' and a 'climate of fear'.

### **Research Question 3: Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals?**

#### *a) Key Messages from the Scoping Interviews*

- Expectations around professional behaviour were similar across different healthcare professions, but professionalism was recognised as culturally and context specific.

#### *b) Key Messages from the Rapid Evidence Assessment*

- The literature suggests that many aspects of professionalism in dentistry are similar to other healthcare professions. The most marked differences appear to lie in the transactional, financial and contractual areas of dental practice. The costs associated with dentistry influence how professionalism is viewed, which may explain why patients express their views of dentistry in similar terms to those of other transactional consumer services. The financial and wider pressures on decisions were identified as a concern for patients and a source of stress and challenge for dentists.
- The wider healthcare literature gives more attention to reporting research on clinician burnout compared to the literature on dentistry,

#### *Gaps in the literature*

- The evidence relating to professional lapses focuses predominantly on individuals and is limited in terms of addressing the respective roles of the dental team, and organisational and system influences on care.

#### *c) Key Messages from the Focus Groups*

- There was some disagreement about whether DCPs should meet the same standards of professionalism as dentists. Some argued that lower standards of professionalism could be applied to dental nurses; others that standards should be applied equally across the team.
- Participants made comparisons with healthcare and other professions. Overall, both dental professionals and public groups noted that professionalism is very similar in the dental and medical professions, and other professions, such as teaching, that require public trust.

### **Research Question 4: The teaching of professionalism – how does the undergraduate curriculum prepare students to meet professionalism expectations and how this is evidenced?**

#### *a) Key Messages from the Scoping Interviews*

- Professionalism was seen as being developed through observation and reflection and can be challenging to assess.
- Enhanced engagement between undergraduate and postgraduate educators and relevant support staff would facilitate satisfactory progression from student to new graduate.

#### *b) Key Messages from the Rapid Evidence Assessment*

- Although formal curricula for professionalism have been defined, teaching and assessing professionalism is recognised as complex. Alongside the formal curriculum, mentoring and reflective practice, role modelling and the hidden curriculum play a notable part in the development of professionalism. No one approach is the most effective or successful for teaching professionalism and multiple approaches are encouraged.
- Students appear to feel that professionalism topics are well covered in the undergraduate curriculum. Applying social media guidelines and determining personal from professional behaviour was a specific area identified for additional support. Qualified dentists identified gaps in their teaching, possibly as undergraduates are often protected from many real-world issues. In addition, students prioritise clinical competence and do not engage as much with 'non-clinical' topics.
- Assessing professionalism is challenging and the use of multiple methods and tools is encouraged for evidencing professional development, including workplace-based assessments and measures that are longitudinal and provide a better view of professionalism. Feedback and reflection can strengthen the value of assessment.

#### *Gaps in the literature*

- Positive concepts of professionalism are rarely explored in the undergraduate curriculum, and there is a lack of research to address the conflict between the teaching of positive and supportive approaches to professionalism and the influence of concerns about fitness to practise in shaping student and trainee attitudes and understanding.
- Technology and social media are emerging issues but the evidence relating to how these can and should be addressed is limited.
- There is some consensus on the overarching concepts of what could and should be taught or assessed in terms of professionalism but there is less agreement on the very divergent approaches to this.

#### *c) Key Messages from the Focus Groups*

- The dental professional groups talked about different generations of dentists, noting differences in training, attitudes to social media, communication skills, and attitudes to self-presentation.
- A number of important aspects of professionalism were identified in the patient and dental professional focus groups, indicating areas for inclusion in the curriculum. These included: addressing unprofessional behaviours of others; fulfilling a wide range of patient expectations; requests for inappropriate cosmetic treatment; navigating social media; awareness of cultural differences; working together as a team and joint responsibility in delivering good care.
- There were discussions about whether and how communication skills can be learned. Some dental professionals thought that communication skills are innate, but others discussed the value of education and training. Members of the public



were not knowledgeable about whether dental professionals received formal communication training but thought they should do.

- Insight and reflection were viewed as important throughout dental training and professional practice. All dentist groups noted how new dentists learn from observing seniors, picking up good and bad habits equally easily.

### **Key Messages from the Modified Delphi Process**

The modified Delphi process provided a wealth of additional information covering, in particular, research questions 1 (public expectations), 2 (how professionalism is defined) and 3 (expectations of different dental professionals and how views might vary by different stakeholder group). The survey comprised 27 items relating to 'unprofessional behaviour' (including workplace behaviour, public behaviour and private, personal behaviour) and 26 items relating to 'professional behaviour' (interactions with patients, workplace appearance and behaviour, public behaviour and private behaviour).

Some aspects appear to be well defined and clear-cut, such as not discriminating against patients or making sexual advances to patients in the workplace. The importance of gaining consent from patients, communicating effectively, and making care decisions based on the patient's best interest was also evident from our results. Other aspects are less clear. Following the second round of the Delphi survey, 18 items remained without consensus. For example, the appearance and presentation of registrants and where their professional life and personal life begins and ends

What is apparent is that many situations are largely context-dependent. Professionalism is a multifaceted construct and whether an action or behaviour is considered to be unprofessional will depend on a number of different aspects: inter-alia, cultural or religious factors, environment and setting, the observer or individual the action is directed towards and their perception, and whether the scenario was a one-off event or a patterned behaviour.

From comparing the views among different groups (dentists, DCPs and members of the public), it was evident that generally, DCPs appear to be the most vigilant or stringent around aspects of professionalism. Dentists on the other hand appeared to be the most tolerant or lenient towards certain behaviours. The public was positioned somewhere between the two.

Statements where there was a high degree of consensus provide an indication of fundamental elements of professionalism in dentistry. Those that did not yield a consensus, in conjunction with the detail provided in open text responses, offer insight into the complexity of many aspects of professionalism and the importance of context.

### **Implications**

1. There is a need for more clarity in terms of *how* professional or unprofessional a behaviour is. Serious unprofessional behaviour worthy of a fitness to practise investigation needs to be distinguished from less serious lapses in professionalism. Such a lapse in professionalism may not imply persistent unprofessional actions and remedial action can focus on learning from the mistake.

2. Members of the public could benefit with being better informed about the financial and business constraints of running a general dental practice and the equipment and technical expenses that are incurred. This may help them to understand the balance of factors that impact on their individual dental care.
3. There is a need for all dental professionals to work together as a team as they have a joint responsibility to deliver the appropriate oral healthcare to patients.
4. Managing the anxious patient and confrontational situations are areas for strengthening throughout the continuum of dental education and training for the whole dental team (including receptionists).
5. The teaching of professionalism should reflect a variety of changing contexts that challenge professionals in the 21<sup>st</sup> century. Up-to-date guidance and support structures should be in place for professionals and members of the public, and regularly updated.
6. Whilst some professionals welcome 'direction', there is a need to instil a positive ethos of professionalism in students and established professionals. It might be useful, when students first learn about professionalism to adopt a positive approach towards professionalism and address the issues of regulation and fitness to practise once that positive ethos is imbedded.
7. There is a need to overturn the present reported 'fear factor' and 'blame culture' that can easily lead to 'defensive' dentistry. In so doing, the objective must be to focus on providing the right care, at the right time, provided by the right person, for all members of the public and instil pride in what dental professionals do.
8. Consistency in approach and engagement were key messages for lifelong learning. This might be promoted through:
  - a. working with education providers across the student/graduate transition.
  - b. promoting reflective practice, peer discussion and interprofessional reviews.
9. Further research is needed on:
  - a. exploring concepts of seriousness in terms of lapses of professional behaviours and how these are mitigated or addressed.
  - b. professionalism beyond the individual, attending to the influence of the dental team, organisations and the NHS system;
  - c. the interface between the law and dentistry and approaches for managing these pressures on professional practice;
  - d. the penalties associated with lapses in professionalism or criminal conviction and what would be appropriate within specific contexts;
  - e. approaches to teaching professionalism and using positive concepts of professionalism in teaching;
  - f. approaches to addressing lapses in professionalism, for example the role of remediation;
  - g. how technology and social media can and should be used;

## PART 1 – INTRODUCTION

### 1.1 Background

The General Dental Council (GDC) seeks to ensure that its work and policies are informed by current evidence. To achieve this objective, alongside conducting its own analysis of data, the GDC commissions research. It uses the findings to co-produce recommendations for education and training, how it sets standards and develops guidance, as well as other areas of regulation. This report concerns the work undertaken for one of two linked projects. Here we report our mixed-method review of professionalism; the companion report presents our rapid evidence assessment of preparedness for practise. Given an overlap between these two linked studies, of necessity there is a small amount of repetition across the two reports.

The study reported here builds on early work undertaken by the GDC. Based on data collected in 2013 (including a survey of 3500 dental professionals, a literature search, interviews with stakeholders in dental and wider healthcare sectors, and complaints and insurance claims data), the GDC reported on ‘risk in dentistry’ (Europe Economics 2014). The risks identified related to competency (lack of skills or knowledge), poor communication and where this related to inadequate record keeping, poor treatment. The report also noted that males were more prone to risk and that the working environment, pressures of workload, financial incentives, working in isolation could promote risk. However, new graduates seemed to have fewer fitness to practise (FtP) cases. Reporting on the *Transition to Independent Practice*, Boak et al (2013) found that there was no evidence of increased risk of an FtP referral or a greater risk to patients from new registrants.

Evidence from FtP cases revealed that concerns raised with the GDC reduced by almost half between 2014 and 2018 (GDC 2019b). From the 336 cases referred to the GDC between October and December 2018, 62% related to clinical treatment investigations. These included treatment planning, actual treatment and aftercare. Issues relating to the 19% of cases considered for conduct included being disrespectful, aggressive, discriminatory or displaying lack of duty of care. In addition, there was evidence of putting financial interests ahead of patients’ best interests, barring patients without explanation, failing to advise on alternative care, ignoring or dealing inappropriately with complaints. Customer service was called into account. Poor explanation of treatment options, carrying out treatment which was unexpected or not understood by the patient accounted for consent concerns (9%). Communication issues were often integral to these cases (GDC 2018).

However, in the Patient and Public Survey of 2017 (Ipsos MORI) 97% of respondents felt satisfied with dentistry in the UK. What was most important to patients was the cleanliness of the practice, the quality of care and knowing in advance the cost of treatment. Only 7% felt that a dentist’s behaviour in their personal time was important. When a dentist was found to have provided the wrong treatment, then the patients/public felt that they should be suspended from the register. The majority expressed a more lenient response to a dentist’s behaviour in their personal life (such as being drunk and disorderly). The exception to this was if the dentist made racist comments. Patients felt that the GDC’s role should be to ensure appropriate training and completing this should be part of the penalty. They felt that dental nurses should not be treated as severely.

The GDC's *Shifting the Balance* was published in January 2017. It sets out the GDC's intention to increase its focus on 'upstream' or preventative regulation. This includes undertaking activities and introducing initiatives aimed to positively influence all registrants, not just the small number who come to their attention when something has gone wrong. One key area of 'upstream' influence that the GDC has is the 'standards' they set for their registrants. Part of taking a more collaborative and supportive approach to regulation involves ensuring that every registrant is familiar and comfortable with the expectations placed on them as registered dental professionals. As well as encouraging registrant familiarity with these standards, it also means making the best use of the data and intelligence that the GDC and their partners hold to identify areas of risk.

## 1.2 Aim of the Review of Professionalism

Although registrants are obliged to work in patients' best interests, there is a lack of a shared understanding of professionalism or what constitutes a professionalism breach (Ipsos MORI 2017). An evidence synthesis can inform the GDC's review of *Standards for the Dental Team* (2013) and their development of Principles of Professionalism. The primary aim of this review of professionalism was to explore and seek consensus on what 'professionalism' means to dental professionals and the public and why being professional matters. More specifically, the review addresses the following questions:

1. What aspects of professionalism does the public expect from dental professionals (what causes a patient to lose trust) and why are these perceived as important?
2. How can aspects of professionalism be categorised (e.g. moral, clinical, personal behavioural; in work, outside work)?
3. Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals?
4. The teaching of professionalism - how does the undergraduate curriculum prepare students to meet professionalism expectations and how is this evidenced?

## 1.3 The Project Team

The Association for Dental Education in Europe (ADEE) has extensive experience in gathering evidence and best practices in the area of dental education (undergraduate and continuing education) worldwide, analysing the findings and developing guidelines. Recent work includes the literature review of CPD for the GDC (ADEE 2019). Members of the project team working under the auspices of ADEE included:

Professor Jonathan Cowpe	Project Manager and Expert Advisor
Professor Alan Gilmour	Expert Advisor, Lead for Preparedness-for-Practice
Professor Alison Bullock	Academic Project Lead and Lead for Delphi and Focus Groups
Dr Ilona Johnson	Expert Advisor, Lead for Professionalism
Dr Argyro Kavadella	Researcher
Ms Rhiannon Jones	Researcher
Dr Sophie Bartlett	Researcher
Dr Dorottya Cserzo	Researcher
Ms Emma Barnes	Researcher
Mrs Elaine Russ	Research support
Denis Murphy	ADEE, Project Administration

Communication with the GDC and project monitoring was facilitated by establishing an Expert Reference Group (ERG) with whom the team consulted throughout the duration of

the project. The ERG membership is listed in Appendix 1. We would like to thank our ERG members, and the scoping interview and focus group participants for their contribution to this research.

## PART 2 – METHODOLOGY

### 2.1 Introduction

We adopted a mixed-methods approach to both the preparedness for practice and professionalism projects. The core part of both reviews was a rapid evidence assessment. Rapid evidence assessments (REAs) are well-suited to the GDC's need to gain an overview of the amount and quality of evidence and identify evidence gaps and so inform future developments. Their rapid nature indicates that they provide a more stream-lined approach to the review and tend not to be as in-depth as a systematic review (Gannan et al 2010). They are, nonetheless, systematic in their approach to searching and assessing the evidence.

The REAs were complemented by the analysis of qualitative data from scoping interviews with topic experts. We consulted with these individuals on both topics. In addition, for professionalism, we utilised focus groups with the public and dental professionals - dentists and representatives from the six groups of dental care professionals (DCP). To seek consensus on the meaning and importance of professionalism, we also conducted a Delphi study which enabled us to reach a wide range of contributors who were geographically dispersed. Working to co-produce conclusions and recommendations with the GDC and other stakeholders, we also contributed to GDC learning events which offered further opportunities for feedback and discussion. Furthermore, we consulted with the ERG at intervals about aspects of these linked projects, in particular regarding the scoping interviews and the Delphi process. We received ethics approval to carry out this research from the School of Social Sciences Ethics Committee (SREC/3390)

By offering opportunities for triangulation and so limiting bias, our mixed methods approach enhances the robustness of the findings. Engaging with stakeholder groups, including patients, gave them voice which facilitates the downstream engagement of the dental workforce with GDC developments informed by this study.

### 2.2 Issue Scoping

We consulted, through scoping interviews, with thirteen topic experts. These conversations were conducted face-to-face or via telephone; one provided an email response. These individuals were identified through discussion with the GDC project team and our own knowledge of the field. We are extremely grateful for their significant contribution to both projects. Alongside developing our scope of the issue, these discussions (with experts and the GDC) signposted us to additional key evidence. Each contributor was provided with an information sheet (see Appendix 2) and asked to consent to taking part.

Following introductions, the team member conducting the interview went through the following questions with participants.

1. How would you define professionalism? what does it mean?
2. What kinds of things do you consider would constitute a 'professionalism lapse'?
3. How is professionalism taught and how do students/trainees evidence professionalism?
4. Do you think professionalism is perceived differently by different stakeholders (the public, professionals, educators)? In what way(s)?

5. How do you think professionalism in dentistry compares with professionalism in other professions?
6. What do you consider to be the biggest threat or challenge to professionalism in dentistry?

## 2.3 Rapid Evidence Assessment (REA)

### 2.3.1 Sources

A search strategy was designed to be comprehensive and support the efficient retrieval of the most relevant literature. We followed the PRISMA guidelines (2019). Electronic databases for papers from peer reviewed journals were searched, using a predefined range of keywords and combinations of these keywords (see search terms below in table 2). We searched various online databases (Medline, CINAHL, AMED, PsycINFO, EMBASE, BNI and the Cochrane Database of Systematic Reviews Web of Science, SCOPUS Life Sciences, Health Sciences, Physical Sciences and Social Sciences & Humanities. We also utilised an academic literature search engine (Google Scholar). Additional references were identified via citation tracking. We received some suggestions from the scoping interviews and ERG meetings.

### 2.3.2 Inclusion and Exclusion Criteria

Our intended inclusion and exclusion criteria are set out in Table 1. The REA considered dental professionals throughout the continuum of their careers – as undergraduate students, new graduates and established practitioners. Included in the evidence are relevant dental studies focusing on professionalism published from inside the UK. In addition, for other healthcare professions, our focus was on systematic reviews which necessarily included literature from beyond the UK.

*Table 1: Inclusion and exclusion criteria*

Category	Inclusion Criteria	Exclusion Criteria
Focus of study	Concerned with professionalism	Not concerning professionalism
Setting and population	Healthcare professionals (limited to nurses and doctors) in primary, secondary or community care settings	Not in healthcare settings
Date of research	Since 2009	Pre-2009
Research methods	All methods	-
Language	English only	Not in English
Publication type	Research papers, official reports, books, book chapters (to be further defined)	Letters, meeting abstracts, editorials (to be further defined)

#### 2.3.2.1 Search Terms

A series of searches using multiple combinations of key search terms were executed which resulted in thousands of returns of potentially relevant publications. The search used an iterative process and secondary reference searching was undertaken of key publications included in this review to cross check and to identify any further evidence. Table 2.

Table 2: Search terms

Search terms used within dentistry literature			
<b>Dentistry</b>	<b>Country</b>	<b>Personnel</b>	<b>Professionalism-related</b>
Dental Dentist*	United Kingdom UK England Scotland Wales Northern Ireland	Staff Student Auxiliary Assistant Hygienist Therapist Surgeon Team Technician Nurse Practitioner Professional Complementary Trainee Graduate Undergraduate Registrant Postgraduate Foundation Vocational Vocational trainee Restorative Denturist Orthodontist	Patient safety Patient risk Patient harm Patient damage Patient injury Patient trust Patient values Patient perception Patient expectation Negligence Misconduct Conduct Incompetent* Competent* Behaviour Behavior Candor Candour Confidentiality Ethic* Integrity Breach Trust Duty Values Accountability Social responsibility Honesty Respect Impairment Professional competence Professional practice Professional practise Professional role Professional autonomy Professionalism Social media Communication Equality Harassment Prejudice Ageism Homophobia Racism Sexism Xenophobia Stereotyping Whistleblowing
Search terms used within wider healthcare literature			
<b>Healthcare professional</b>	<b>Literature type</b>		<b>Professionalism-related</b>
Doctor Medic Foundation doctor Nurse Nurse practitioner Nurse prescriber Consultant nurse Nurse specialist Physician	Systematic review		As above



The search strategy was developed and refined iteratively as initial results were generated. Subject heading searches proved to be of limited value. Keyword searches were based on five main concepts derived from the project's research questions and initial test searching: dental professions, professionalism, support and patient safety. Each was elaborated by synonyms and closely related terms used in full or attenuated form. Keyword searches were undertaken singly and in various combinations to progressively focus and circumscribe search results.

### *2.3.3 Selection Process and Data Extraction*

The process for selecting (and eliminating) the data collected via the search methodology is summarised below and in Figure 1. Prior to this first 'identification' stage (see figure 1) several thousand articles were identified. Screening and undertaking multiple searches reduced this to the more manageable initial screening stage of 1,579 articles.

#### *2.3.3.1 Screening*

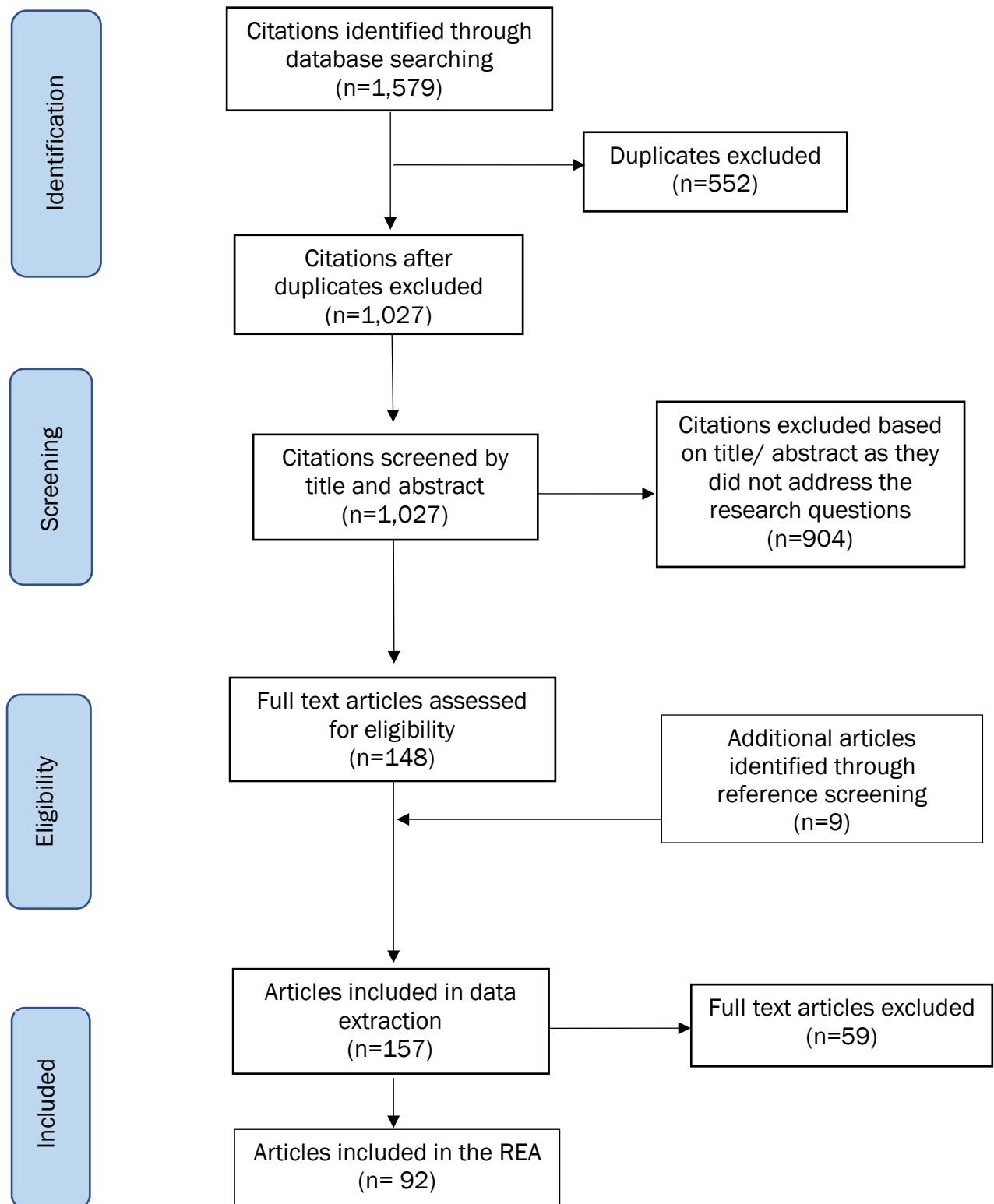
After searching the electronic databases and removal of duplicates, we scanned all titles and abstracts and excluded items based on our predefined criteria. After undertaking a concordance check (to ensure criteria were understood and applied consistently), two members of the team worked independently and in parallel. Any uncertainty was brought to the wider team and consensus sought. We strived to ensure robust screening to avoid time spent in retrieving full texts which would have turned out not to be relevant.

However, we also noted that in order to select the maximum number of high-quality papers, the researchers occasionally selected papers outside these criteria. These exceptions were selected on the basis of quality (as concluded from the abstract) and the high relevance to the project research questions.

Endnote was used to manage the screening process; database search results were imported into EndNote and title/abstract screening carried out within the programme. This ensured an accurate record of titles excluded and assisted with full paper retrieval. Following PRISMA guidelines, a flowchart displayed the number of items identified, screened, assessed for eligibility and included (See Figure 1).

The search of databases for professionalism literature identified 1,579 publications. Following elimination of the duplicates, 1,027 publications were left for screening (titles and abstracts). Non-relevant papers (n=904) were removed. The full texts of the remaining 148 publications were sought. A further nine publications were scrutinised. On an initial review of full texts, further publications were removed as not relevant (n=59). This resulted in 98 publications which were considered for data extraction.

Figure 1: PRISMA flow diagram detailing the search process



### 2.3.3.2 Data Extraction

During this process, the project team members performed an additional elimination and selection process, when they identified that on close reading of a publication, it did not fulfil the selection criteria or was judged not relevant. The final number of publications contributing to the data recorded in this literature review was 92. The full text of included publications was read, and the relevant data extracted and recorded on a data extraction template. This template reflected that used in the preparedness for practice study, with modifications. To quality assure the process, the data extraction template was piloted on 10 articles, reviewed by the team members and modified, where necessary.

For each publication we extracted and recorded: reviewer and date, citation, year study began, country, participants (size and type), research methods, assessment of methodological quality, findings relevant to the question, recommendations, and overall rating of relevance.

The strength of the study design was assessed using a simplified levels of evidence model widely adopted (Essential Evidence Plus 2020) (See Table 3). In Table 4, we report the quality levels of the papers referenced in each section of the report. Total numbers in the table exceed 98 as publications are cited in more than one section.

*Table 3: Study design quality levels*

Grade Ia	Systematic reviews of RCTs
Grade Ib	Randomised controlled trials
Grade IIa	Systematic reviews of studies without randomisation
Grade IIb	Studies without randomisation: single group pre and post intervention, cohort, time series, matched, case-control studies
Grade III	Other non-experimental studies
Grade IV	Opinions and case reports

A final record of the evidence collated, the references and their quality levels were scrutinised by two team members independently and then collectively to construct Table 4.

*Table 4: Study design evidence quality levels*

Section	Quality Level					
	Grade Ia	Grade Ib	Grade IIa	Grade IIb	Grade III	Grade IV
	Systematic reviews of RCTs	Randomised controlled trials	Systematic reviews of studies without randomisation	Studies without randomisation: single group pre and post intervention, cohort, time series, matched, case-control studies	Other non-experimental studies	Opinions and case reports
4.2 Professionalism within the context of the dental surgery environment	0	0	1	0	17	4
4.3 Interpersonal experience of care and qualities of the clinician	0	0	5	2	18	13
4.4 Professional-personal divide and social media	0	0	2	0	4	3
4.5 Teaching & Education	0	0	11	1	24	7
<b>Totals</b>	<b>0</b>	<b>0</b>	<b>19</b>	<b>3</b>	<b>63</b>	<b>27</b>

## 2.4 Focus Groups

The ADEE project team, in partnership with the GDC project team, agreed to separate focus group meetings for dentists, DCPs and members of the public. Each participant was provided with an information sheet and requested to consent to taking part (see Appendix 3). Those dental professionals who participated were offered 2 hours of CPD certification. In compliance with the GDC's CPD guidance, anonymous feedback was received (see Appendix 4, the feedback form).

Each focus group was facilitated by members of the ADEE project team and, with consent, the discussions were recorded.

As an introduction, we asked members of the public to say one thing about their experience of dentistry. For the dental team members, we asked them to say one thing that gives them a sense of pride in being part of the dental profession. Team members then facilitated responses to these main questions:

1. What does professionalism mean?
2. Lapse in professionalism: what things would you consider to be 'unprofessional'? What would cause patients to 'lose trust' in a member of the dental team?
3. In terms of professionalism, what do you think matters most to the public? Do you think the public's view of what matters is the same or different to what dental professionals think?
4. Do you think new members of dental teams are prepared well to be professional?
5. How do you think professionalism in dentistry compares with professionalism in other areas? What might be similar or different to what professionalism means in other healthcare professions (like nursing, medicine); or in other professions (e.g. the airline industry, the legal profession, teaching)?
6. Looking to the future, what do you consider to be the biggest challenges to professionalism?
7. Is there anything else you would like to add [asked of each individual in turn]?

### *2.4.1 Focus groups with dental professionals*

In Birmingham, in September and October 2019, we ran four focus groups with dentists, each of two hours duration, accommodating 19 attendee dentists (9 males, 10 females). The participants covered a wide range of ages from newly qualified to established dentists.

Given the geographical location of the meetings, we enlisted the support of the Dental Postgraduate Dean and Manager in HEE Midlands & East who circulated the invitation to dental professionals through their deanery database.

As part of certifying the 2 hours of CPD, dental professionals completed an anonymous feedback form. A number of them agreed to be involved in any further planned investigations and in particular the Delphi Process.

### *2.4.2 Focus groups with DCPs*

A focus group for DCPs took place in November 2019 in Nantgarw, South Wales. The dental postgraduate section of Health Education and Improvement Wales (HEIW) issued an invitation through their dental professionals' database. There were 13 attendees (2 males, 11 females). There were eight dental nurses, two hygienist/therapists, one dental

technician and one clinical dental technician. At least three of the attendees were actively involved in education and management.

We did not receive a sufficient number of responses for DCPs in HEE Midlands & East to run a separate DCP focus group in Birmingham. The offer was made to join one of the focus groups with dentists. Instead, two opted for individual telephone contact.

#### *2.4.3 Focus groups with members of the public*

'Community Research' recruited members of the public for two focus groups. These took place in October 2019. There were five males and eight females. Age ranges were diverse (20-40 n=7; 40-60 n=3; >61 n=2). Seven were White/British, three were Black/British, one was Asian/British, and one was of mixed ethnicity. Eight had attended a dental practice in the last 6 months and four in the last 6-12 months. Seven individuals attend their dentist every 6 months, two every 12 months and three only when they need treatment. Eight individuals attend an NHS dentist, three a private dentist and one attended an NHS then a private dentist.

In addition, the local Community Health Council, in South Wales, was approached given their previous involvement in supporting similar activities relating to professionalism as part of the undergraduate BDS programme at School of Dentistry, Cardiff University. They agreed to recruit to a focus group of members of the public using identical criteria to that used by 'Community Research'. This took place in November 2019 at Aneurin Bevan community Health Council, Cwmbran. There were 6 participants (3 males, 3 females) again facilitated by two project team members

## 2.5 Delphi Process

To extend the reach of the focus groups, and to explore consensus on what 'professionalism' means and why it is important, we ran an online modified Delphi. Delphi is a consensus method in which participants respond to two or three rounds of the survey. Those items that do not reach consensus in the first round are included in the second round and participants are asked to reassess their answers based on an anonymous aggregate of responses from the first round. This may then continue for a further third round until consensus is achieved. By informing participants of the results of the previous round, opinions converge towards a collective consensus (Powell, 2003).

Our method was a 'modified' version of the Delphi process (Powell, 2003) as we did not include an unstructured first round that allows participants to submit views on the topic of investigation which then informs the specific content of the questionnaire in the later rounds. Instead, our approach was more in line with that of Duffield (1993) whereby the content of the Delphi questionnaire was based on the analysis of existing literature.

The kinds of statements we included were designed to help determine the boundaries of acceptable professional behaviour. Statements were identified from the scoping interviews, the REA and focus groups and were presented in two groups: 'unprofessional' (negative) behaviours and 'professional' (positive) behaviours. For the statements in the unprofessional behaviours group, participants were asked to indicate the extent to which they judged the behaviour or attribute to be unprofessional for dental professionals. The response options were 'not unprofessional', 'moderately unprofessional' or 'highly unprofessional'. For the statements in the professional behaviours group, participants were asked to indicate whether they found each behaviour or attribute to be either 'not necessary', 'desirable' or 'essential' for dental professionals.

Consensus criteria were set in advance and were interpreted as where at least 70% of participants rated the statement in the same way

Further information on the distribution of the Delphi and other methods is provided in section 6.2. The survey questions are displayed in *Appendix 5*.

## 2.6 Co-production Activities

Throughout the study we worked closely with a project team at the GDC. Project Team members were invited to three events during the duration of the project: GDC Policy and Research Board (PRB) meeting (September 2019); GDC Preparedness for Practice of UK Undergraduates conference (November 2019) and 'Moving Upstream' update stakeholder learning event (February 2020). The PRB event and the 'Moving Upstream' events were relevant to this review.

We were invited to run a workshop, facilitated by members of the project team, for the GDC's PRB. The workshop commenced with an outline of the ADEE projects on professionalism and preparedness for practice but centred on professionalism. The workshop adopted a modified world café method. PRB members were divided between four tables. Each table had a 'host' who collated the information from the discussions. Ideas/views were recorded on post-it notes and collated on a flip chart. Each table group spent around 15 minutes discussing the question on that table and then rotated to the next table, covering the questions on all four tables over a period of one hour. After each rotation, the table 'host' provided a brief summary of the points already raised. This facilitated the new group to add to existing points or raise additional points.

The aim of the workshop was to consider firstly *where the GDC is now* and secondly, *where would they like to be and how could they get there*.

### ***Session 1: Where are we now?***

*Table 1:* How would you characterise the GDC's current approach to describing professionalism through its Standards?

*Table 2:* What's working well in terms of professionalism in dentistry?

*Table 3:* What's not working well in terms of professionalism in dentistry?

*Table 4:* To what extent do you think the GDC's current characterisation of professional standards protect the public, help to maintain confidence and drive professional behaviour?

### ***Session 2: Where would we like to be and how do we get there?***

*Table 1:* How might the GDC, using the standards we set for registrants, better respond to concerns the public might have, for instance

*Table 2:* Thinking about a professional's journey from education into practice and through their career, in what ways can the GDC help develop a common and shared understanding of professionalism at each stage of that journey?

*Table 3:* What are the emerging professionalism issues and challenges and how do we address these?

*Table 4:* How would we keep pace with changes and developments as they relate to professionalism?

The summary of the PRB discussions is described in section 8.1.

In addition, the project team were asked by the GDC to contribute to a learning event for a range of stakeholders on their progress with their policy of 'Moving Upstream'. Three team members attended this event in London in February 2020. One team member chaired one of the panel sessions on professionalism. The focus for the panel session was a series of four questions (accompanied on each power-point slide with quotations) from the recently completed Delphi survey. Following an introduction from the chair, each of four panellists addressed one question. This was followed by further panel discussion and questions and points raised from the audience. A summary of this event is recorded in section 8.2 and *Appendix 6*.

In the broader context of the project, the findings from the workshop and learning event were considered along with the findings from the project scoping interviews, the REA and the focus groups and the Delphi survey to inform the analysis and conclusions.

## 2.7 The Expert Reference Group

One single Expert Reference Group (ERG) was established and consulted in relation to both the professionalism and preparedness for practice studies. The group (*Appendix 1*), was consulted at three points during the project. Initially, they were provided with information about the study, including the project plan and milestones. They were consulted on the questions to be addressed in the scoping interviews. A discussion took place via video between ERG members and ADEE team members in November 2019. Discussions centred primarily on the draft report and on the analysis of the evidence from the scoping interviews with topic experts. A further video discussion took place in January 2020. Discussions then centred on findings related to the professionalism study. Between these meetings, email exchange was had with some members of the ERG. The views of the ERG members were taken into consideration when refining evidence from both aspects of the project to compile the final reports.



## PART 3: KEY FINDINGS FROM THE SCOPING INTERVIEWS

To complement the rapid evidence assessment and to inform our understanding of the issues related to professionalism, we undertook a number of scoping interviews.

### 3.1 The Data and Analysis

We conducted 13 scoping interviews with a purposively selected sample of experts. These individuals were knowledgeable about both professionalism and preparedness for practice (the findings on the latter we detail in our companion report). The experts were professionals in dentistry (seven respondents), healthcare (two respondents), medical education (three respondents) and aviation (one respondent). All were senior in terms of their career stage. Four were male and nine were female. Eleven of the interviews were via telephone, one was conducted via Skype and one of the responses came in the form of an email. The average length of the telephone and Skype interviews was 49 minutes<sup>2</sup>. In reporting the data, we use pseudonyms to protect the anonymity of the interviewees.

Themes were identified through a process of inductive coding. In this report we provide a short description of each code and give extracts to illuminate the code. A short depiction of the codes, organised into thematic categories, is set out in Table 5. It includes the number of times each of the codes was used across the interviews. Each stretch of talk could be coded for multiple themes, and there was considerable overlap between certain codes. In the text we indicate in how many interviews each code was used. For example, there were 31 extracts of talk that was coded as relating to 'definition' (Table 5) and the code was used in all interviews (see description under the heading 'definitions'). We only report codes that were discussed at least five times.

### 3.2 Overview of Findings

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<sup>2</sup> One interview was with two individuals.

Table 5: An overview of themes and codes for professionalism

THEMES\CODES	Number of times
principles\definition	31
principles\regulations	43
principles\ethics and values	33
principles\motivation	22
principles\motivation\altruism – working in patients' best interests	25
principles\motivation\financial	19
principles\health	3
principles\health\mental health	9
Lapses\definitions	68
lapses\outside of workplace	21
lapses\dis/honesty	15
lapses\social media	14
lapses\((not) looking the part	12
lapses\complaints	8
attitudes and behaviours\interacting with patients	43
attitudes and behaviours\working in a team	26
attitudes and behaviours\adapting	17
attitudes and behaviours\confidence	3
attitudes and behaviours\dealing with uncertainty	1
contexts\healthcare	27
contexts\culture	26
contexts\generations	12
contexts\other professions	12
learning and development\challenges	43
learning and development\insight	37
learning and development\insight\limits	3
learning and development\clinical competence	16
learning and development\learning by observing	16
learning and development\safety	15
learning and development\lifelong learning	8
learning and development\assessment	30
learning and development\assessment\practical	2
learning and development\autonomy	4
learning and development\learning by doing	4
learning and development\'real' practice	4
learning and development\support	4

We organised the data into five overarching themes, concerned with principles, lapses, attitudes and behaviours, contexts, and learning and development.

### 3.3 Theme 1 – Principles

The codes in this theme refer to principles that underpin professionalism, but which generally are not directly observable. More observable behaviours are reported under other themes.

#### 3.3.1 Definitions (*principles*)

This code was used to capture participant definitions of professionalism. Definitions were provided in all interviews. The elements of the definition that were highlighted by the interviewees related to two main sub-themes: underlying principles (*ethics and values, regulations, motivation or altruism*) and professional behaviours (*adapting, working in a team, and interacting with patients*). *Clinical competence*, which does not fit in either

classification, was also noted as a key element by three interviewees. Most interviewees mentioned at least one element from both groups in their definitions, but David, Zoe, and Sophie mentioned only *ethics and morals*, while Nick and Maria focused on behaviours.

*Zoe: I always think of professionalism as behaving in a way that you know you should even when nobody else is watching. So I guess it's one of my core values and beliefs.*

*Gemma: Team working as well. So recognising other people's worth and working well with your team and recognising oneself as only part of the team.*

There was more variation in the definitions of professionalism than those given for preparedness for practice.

### 3.3.2 Regulations

Participants referred to regulations, rules and standards in ten interviews. This code was used for reference to specific written rules regulating professions. These were discussed in the context of teaching theory, putting theory into practice, and the rules guiding behaviour.

*Emily: We have a Code... So an individual would not be acting professionally if they did not [follow] that.*

### 3.3.3 Ethics and Values

Participants referred to ethics, morals, values, and beliefs that guide professionalism in eleven interviews. In comparison with *regulations*, these referred to ideals that are applicable to a wider context.

*Gemma: Ideally there would only be a central core to professionalism which would be the individual's belief system, attitude and approach to everything that they do, ... not just in the workplace but also in life outside.*

### 3.3.4 Motivation

Interviewees referred to the importance of motivation or intention in a professional context in seven interviews.

*Rhian: I think somebody who is truly professional, it means that sometimes they do what appears to be the wrong thing, but they do it for the right reason. ...If you knew the full context, it was absolutely appropriate.*

*Freya: I think the intention is very important. If you do something with the intention of causing ...harm ... you know, if it's a deliberate intention.*

This theme had two sub-codes, one related to altruism and the other to financial motivation.

#### 3.3.4.1 Altruism – working in patients' best interests

This code was used when interviewees talked about professionals who are motivated by helping people and prioritising the interests of their patients. It was mentioned in ten interviews.

*David: Well [patients] would expect that any clinician... will automatically be working in their best interests at all time.*

*Gemma: You should put patients' interest first.*

### 3.3.4.2 Financial

There were also discussions about the interplay of providing care and running a business and being motivated by financial gain. This code appeared in eight interviews.

*Gemma: I think the difficulty that can be put in the way of dentists is that you're not just a healthcare professional, but you're also a businessperson and it's getting those two parts of your role right. And it's understanding that they can sometimes be competing, and you may be tempted to behave in a way that's not truly professional in order to keep the business side of things going.*

*Rhian: I remember when I was at university going to a new dentist and he decided all my fillings needed replacing. So I had no idea whether he was right or wrong. I trusted him, and he replaced them all. And he made loads of money on that. And when I went to [another] dentist, he told me they didn't need replacing and he made money on it. And that I felt that was extremely unprofessional and it's because you don't know... I had no knowledge of whether my fillings needed replacing or not, but he made a massive load of money.*

### 3.3.5 Mental Health

Four interviews made a link between mental health and professionalism.

*Kate: It [austerity measures] impact on burnout and stress, which then has another knock-on effect on professionalism. Because when you're burnt-out and you're stressed you don't have the cognitive capacity to take a deep breath ... and when you're under time pressure, you just do.*

## 3.4 Theme 2 – Lapses

Lapses were discussed in eleven interviews. There were examples of extreme cases which were framed as unambiguously unprofessional (for example fraud, breaching confidentiality, stealing, sexual harassment, violent assault) as well as discussions of grey areas (such as making problematic comments in the pub, making a mistake under pressure, arriving a little late to clinic, 'white lies', being rude outside of the clinic). Some participants highlighted the importance of context when discussing lapses and noted potential mitigating circumstances: one-off incidents, good intentions, honesty after the fact, and learning from past mistakes. There were also discussions of potential consequences of lapses to the professional and patient involved as well as the reputation of the practice or dentistry in general.

### 3.4.1 Definitions (lapses)

Eight interviews contained definitions of lapses.

*David: I think it probably relates to deliberate acts. ...If you deliberately do something that you know isn't right and isn't in the best interest of the person you're interacting with or the situation you're interacting in, then I think then you start to think, yeah there's a professional issue here.*

*Gemma: ... examples of behaviour where students have put themselves and their own personal progression and achievements ahead of the individual patient....You start some treatment on a patient. It's all going quite well. You have a particular item of treatment that you need to do to complete a portfolio. You do that. The patient is then of relatively limited use to you. So you don't bother to send them an appointment back out. You don't follow them up for recall.*

### 3.4.2 Outside of workplace

In discussing lapses, seven interviewees provided examples of behaviour outside of the workplace which could impact perceptions of professionalism.

*Zoe: I think if we showed pictures of people partying very hard, as a patient I'd raise an eyebrow about that. Perhaps any kind of racial, or not inclusive with regard to gender, comments.*

*Gemma: If you go out and get drunk and get yourself in trouble with the police that will affect your registration.*

### 3.4.3 Dis/honesty

Six interviewees identified honesty as a key element in professionalism.

*Rhian: To acknowledge when things go wrong and share it... We're all human... The seniors make mistakes and they're happy to say 'yeah I did it as well'.*

*Claire: With dishonesty, in-clinic, off-clinic, it's all the same for me. I think whether you're dishonest about an essay that you've written or you're dishonest on the clinic about something else that's happened in a clinical environment...I think it's a fundamental tenet of professionalism that crosses whether you're in or out.*

### 3.4.4 Social media

Social media was presented as challenge, if not a threat, to professional conduct in eight interviews.

*Emily: I think it is a challenge to how people demonstrate their professionalism. [Q]uite clearly, inappropriate use of social media will constitute that [a professionalism lapse].*

*Zoe: The continual expansion of social media...I think that's a big issue... So younger graduates, younger students that's how they're used to expressing an opinion because that's how they live. So their communication skills are through that medium which is much more difficult to monitor and to consider appropriate boundaries.*

### 3.4.5 (Not) Looking the part

These comments related to the presentation of professionals. They were distributed across eight interviews.

*Rhian: I remember people talking, not that long ago, about students going on wards with...when it was trendy to have like the short tops and show your belly-button, and I can remember a doctor saying 'that's not professional, people shouldn't turn up like that'. And I think that's right actually. I think we do need to present a professional image, but that will change over time and it'll be about culture as well.*

*Nick: I was in a conversation recently... around professional comportment and dress codes and someone was suggesting that that required covering of tattoos. I don't think that today the presence or absence of a tattoo reflects upon someone's professionalism possibly at all.*

### 3.4.6 Complaints

Four interviewees mentioned official complaints in relation to professionalism. In one of these, the interviewee implied that professionalism can be driven by fear of complaints rather than a desire to do things 'right'.

*Bryan: We hear from foundation dentists that ... if they do something that might be unprofessional they are told, 'if you were to do that in a practice out of here, you'd be up before the GDC before you know it'. Rather than saying, 'well actually is that really in the best interest of the patient? Is that what you would do if you were treating a family member?' Give them the bigger picture rather than putting the frighteners on them.*

### 3.5 Theme 3 – Attitudes and Behaviours

The codes in this theme relate to attitudes and behaviours that are seen as indicators of professionalism.

#### 3.5.1 Interacting with patients

Communicating with patients was highlighted as an important aspect of professionalism in eleven interviews. Participants suggested that patients value highly clear and respectful communication. Furthermore, this is an aspect they can easily evaluate, whereas they may not be able to tell whether the procedure was needed or carried out well.

*Claire: The patient having consensual extraction literally was so nervous they [the patient] decided not to do it. Then they [the patient] ended up spending some time talking to the student and then agreed to have it done because of how the student had taken their time with them.*

#### 3.5.2 Working in a team

Ten interviewees indicated that professionals need to be able to work together with their team.

*Kate: I often think that one of the threats to professionalism is inter-professional working, unless we can get rid of hierarchy and stereotypical thinking. So let's say doctors and nurses or other healthcare professionals, the pecking order ... power... gets in the way ... Stereotypes build up and can overspill into behaviours.*

#### 3.5.3 Adapting

Six interviewees highlighted the importance of adapting to different situations as a professional or commented on changing standards in professionalism.

*Claire: I think professionalism evolves... you change as you go through your career as you pick up new skills and as you face new challenges. So that's why professionalism I think is multi-dimensional because it encompasses so many different aspects and attitudes are part of that. The attitude to be able to train and adapt and be able to move even in difficult times in an ethical manner can be very important, I think.*

### 3.6 Theme 4 – Contexts

The codes in this theme refer to specific contexts which can shape expectations around professionalism.

#### 3.6.1 Healthcare

Ten participants discussed professionalism from a healthcare rather than (or in addition to) a dental perspective.

*Bryan: Personally, I'd quite happily see some common shared things across everyone that delivers healthcare to the public because there are core things*

*around what it is to act professionally with the public being a healthcare professional.*

### 3.6.2 Culture

There were discussions about the role of culture in professionalism in eight interviews.

*Rhian: Well I think it is context bound. If we give the dentists, 'this is a guideline', but I think there is always some interpretation ... I think you've got to understand the culture that you're dealing with.*

*Maria: I think obviously this is cultural, ... inner city to outer city... depending on the social group that you are with.*

### 3.6.3 Generations

Discussions about generational differences, in professionals and patients alike, appeared in nine interviews.

*Freya: If my mum went to the dentist and they had a visible tattoo on their arm, my mum would be horrified. Because her expected norms in the way she was brought up and her age group and everything else is that tattoos are not acceptable. But for a 23 year old or an 18 year old, even a 40 year old maybe, someone from a different culture, a tattoo might be something completely acceptable.*

### 3.6.4 Other professions

Ten interviews compared dentistry with other professions outside of healthcare (aviation, teaching, banking, law, accounting, politics, football, engineering, manufacturing, armed forces).

*Sophie: Professionalism within nursing is comparable with other professions for example health, law or the armed services.*

*Nick: I suspect that people who make craft or have an artisanal furniture manufacturing probably consider themselves to have a need to behave professionally with their clients or suppliers or colleagues.*

## 3.7 Theme 5 – Learning and Development

The codes in this theme relate to ways of learning, and methods of assessment.

### 3.7.1 Challenges

This code refers to challenges to professionalism in general (such as social media and an increased appetite for cosmetic treatments) or specific situations in which professionalism is challenged. The interviewees suggested that challenges are necessary in developing a deep understanding of professionalism. It was used in eleven interviews.

*Nick: With the erosion of the NHS, the increase in popularity of cosmetic treatment with the growth in corporate provision of dentistry I suspect that patients' expectations will continue to change... and I think that this is probably a bit uncomfortable for some people who consider themselves to be healthcare providers to meet the expectations of another person who thinks they're a consumer, not a patient. I think there's challenge there.*

*Claire: I think it's something that you grow and develop and your skills related to professionalism evolve and become more nuanced as you deal with more complex situations.*

*Kate: Sometimes you have to take that really tricky call as to whether or not, you know, what you do is okay because you're in a dilemma situation.*

### 3.7.2 Insight

Insight and reflection were also highlighted as key components of professionalism in ten interviews.

*David: I suspect those people who reflect well are already demonstrating a high degree of professionalism because... part of being professional is actually analysing your own actions and reflecting upon them. 'Did that go well? If not, what could I learn from that? How can I do that better?'*

*Claire: You could say, 'well my strength is this. I'm really good at doing this, but actually the thing that I need to work on is this'. That kind of insight I think is professionalism.*

### 3.7.3 Clinical competence

Seven interviews identified clinical competence as an aspect of professionalism.

*Emily: For me [professionalism is] really looking at whoever is considered behaving in a professional manner, is that they have the right knowledge and skills to practice autonomously*

### 3.7.4 Learning by observing

These discussions referred to the impact of role models (good or bad) in developing professionalism. They were spread across nine interviews.

*David: You can teach it that way by direct teaching, but I think also it's the behaviours of those around you who act professionally. So if you're in an environment where there are good examples of professionalism and professional practice is carried out, then you're going to acquire that by almost like osmosis, and if you're in an environment where those values are not taken seriously or seen of value then I suspect there is a risk that you will fall into the trap of going the same way.*

### 3.7.5 Safety

In ten interviews concern for safety was mentioned as an aspect of professionalism.

*Phil: Whatever you do your primary concern has to be to ensure safety... that's got to be your primary concern.*

### 3.7.6 Lifelong learning

These comments indicate that professionals need to continue learning throughout their career. They came from three interviews.

*Phil: A necessity to be up-to-date on current learning, up-to-date on skillsets, up-to-date on technology, up-to-date on medical advances... what do I need to do to make sure that the ... regulatory body is going to be comfortable with me practicing.*

### 3.7.7 Assessment & Monitoring & Support

Eleven participants gave their views on the assessment and evidencing of professionalism, including challenges.

*Freya: If you go onto clinic and you have a supervisor, they are always going to have an opinion on whether someone is professional or not. And sometimes that's just going to be an instinct, isn't it? That sort of expert instinct, and*



*breaking that down into what it was is sometimes quite difficult to do... It's difficult because we'll never really understand anyone's intention.*

*Kate: So it's not about sitting a situational judgement test or ticking a few boxes here, there and everywhere. It really is about getting feedback from people around you in terms of how do you act. Not, do you know the best way to act, but do you act that way. ... I do think 360-degree feedback is probably the best way.*

One of the participants drew attention to the Cardiff and Swansea based medical schools' engagement with the Postgraduate, Professional Support Unit (PSU) of Health Education and Innovation Wales (HEIW). Representatives from each organisation meet on a regular basis to share and monitor student and foundation doctor progression through the transition of undergraduate and postgraduate training. This is designed to help facilitate support for student/graduate doctors who are recognised as struggling. This has been seen, by local stakeholders, as a positive way of supporting young doctors and promoting engagement between educational supervisors across the continuum of training.

### 3.8 Summary

The scoping interviews complement the report of the REA and should not be read in isolation. That said, it is helpful to summarise the main findings from just the scoping interviews and map the findings to the four research questions of interest. In summary, those areas are: 1) public expectations and why these are perceived as important; 2) categorisations of professionalism; 3) comparisons between dental professional groups and comparisons with other professions; 4) teaching and evidencing professionalism.

We provide a summary of the main points arising from the interviews and indicate in brackets after each point which research questions they address:

1. Often interviewees found it easier to define professionalism by discussing lapses in professionalism (1,2).
2. In most cases breaches in professionalism were framed as 'lapses', meaning that behaviour in a particular situation may be unprofessional without implying that person is inherently unprofessional (1).
3. There was a recognition that everyone makes mistakes, and that the important thing is to learn from them (1,2,4).
4. Interactions with patients were discussed almost twice as frequently as interactions with other members of the team (1,2).
5. It was suggested that professionalism develops in challenging situations (4).
6. The general opinion expressed by these interviewees was expectations around professional behaviour were similar across different healthcare professions, but professionalism was recognised as culturally and context specific (3).
7. Some interviewees noted that there can be a tension about the balance between patient interests and financial interests (1,2).

8. To an extent, professionalism was seen as extending beyond what happens in the clinic: some expected professionals to behave in an ethical fashion when it has no impact on patients (1,2).
9. The analysis suggests that professionalism is developed through observation and reflection and can be challenging to assess (4).
10. Clinical competence was discussed less frequently than in relation to preparedness for practice. One interviewee explained that they viewed clinical competence as a prerequisite for professionalism (2).
11. Engagement between undergraduate and postgraduate educators and relevant support staff would facilitate satisfactory progression from student to new graduate (4).

## PART 4 – RAPID EVIDENCE ASSESSMENT

### 4.1 Introduction

Wellie (2004) defined professionalism as *‘the social contract between the profession and the public (which) entails a collective responsibility of the members of the profession to serve the public good’*. The author suggests that this definition allows for consideration of both ‘active’ actions which are aggressive and disrespectful as well as ‘passive’ actions such as poor timekeeping.

This rapid evidence assessment identified a range of papers relating to the multifaceted aspects of professionalism in dentistry. Papers covered various aspects of professional behaviours and experiences expected of dental professionals with studies including voices from patients and professionals. In addition to studies, there were professional commentaries, review and discussion articles examining aspects of professionalism.

This evidence from the literature is presented in four main sections:

- professionalism in the context of the dental surgery environment;
- interpersonal experience of care and qualities of the clinician;
- professional-personal divide and social media; and
- teaching and education.

We summarise main messages at the end of each sub-section and include a final section in which we relate the findings from the REA to the four research question areas of the study.

### 4.2 Professionalism within the context of the dental surgery environment

Patient and public experiences of dentistry include expectations of care and views of what is expected in the context of the dental surgery environment. Articles examined aspects related to the environment of care and service including, professional roles in dentistry and facets of the care expected from dental professionals, teamwork, the provision of a safe and clean environment for care, and time management.

#### 4.2.1 Professional roles and expected care

A range of publications reported views of what is and is not appropriate for dental professionals to do, and their role within the dental surgery environment.

##### 4.2.1.1 Studies including patient perspectives

Articles which reported the patients’ perspective focused on elements of services and care and the environment in which this was delivered. These papers focussed on an overarching sense of a good service and experience (Zijlstra-Shaw et al 2013, Tickle et al 2015, Cope et al 2018)). However, literature which included patient and public perspectives was predominantly focussed on expected practices of dentists and few articles explored expected roles of other members of the dental team.

Zijlstra-Shaw et al (2013) in a study which included patients and a range of other stakeholders, explored the concept of professionalism. Accountability for the work being carried out was described as a central part of professionalism. Professionalism was defined as:

*the manner in which one reflects on and reconciles different aspects of professional practice, which demonstrates acceptance of professional responsibility and accountability. It is manifested in the manner in which work is carried out. The balance of the various aspects will vary with and be appropriate to the context while accountability means that the professional is expected to be able to justify his/her actions to the patient, the profession, the society in which they work and themselves.*

Tickle et al (2015), in a survey of the public in England, assessed the quality of dental care received. Twenty percent recorded that their care was below expectations. They felt they did not get value for the costs they incurred and had to wait too long for appointments. Whilst communication skills, being polite and feeling at ease when at the dentist received positive responses, there were a series of quality factors where 40% or fewer respondents gave a positive response. These included access to care, good treatment, professionalism within the practice, cleanliness and hygiene, treatment that did not result in pain, cost value and feeling at ease during their visits.

In a study relating to patient expectations of dental care, Cope et al (2018) examined patient consultation behaviour. They found that this was influenced by patients' interpretation of their symptoms; their perceptions of the scope of practice of primary care practitioners; the comparative ease of navigating medical and dental care systems; previous experiences of dental care, including dental anxiety and dissatisfaction with prior treatment; and willingness and ability to pay for dental care.

#### **Summary points**

- Studies, exploring patient perspectives on dental care, were consumer experience focussed (Tickle et al 2015, Cope et al 2018)
- There were mixed opinions on what professionalism looked like in the dental care setting (favourable around communication-related issues; less favourable with perceived lack of access to care and high costs) influenced by a range of factors (including dental anxiety, socio-economic status, poor prior experience and cost).

#### *4.2.1.2 Studies featuring professional perspectives*

Articles which did not include the patient perspective and only provided a professional viewpoint focused more on specific skills and training rather than the experiences of patients.

Oliver et al (2016), utilised an online questionnaire to ask those who were fellows and members of the Faculty of General Dental Practice (UK) what they would have liked to learn when at dental school. The respondents reported on a range of clinical skills but also highlighted skills in communication, dealing with patients and leadership. The views of dental foundation educators/trainers about their new graduates' skills in communication and professionalism were investigated by Gilmour et al (2014). An online survey was made available to trainers in dental foundation training schemes across England and Northern Ireland. They compared what the trainers expected of a new graduate with what they experienced from supervising their first-year graduate dentists. Across the training schemes, 28% of the dental foundation trainers felt that their experience of new graduates in the areas of communication and professionalism fell short of what they had expected. Although 78% felt that their trainees demonstrated an appropriate ethical philosophy in the working environment and in providing care for their patients, the investigation identified the need for addressing these issues within the

undergraduate programme. Also, they identified a need for new graduate trainers to recognise that the foundation year facilitates and provides the opportunity to strengthen these non-clinical skills which are vital to the new dentist maintaining high standards and supporting patient safety throughout their career.

In Scotland, Gnich et al (2015) investigated dentists' views of fluoride varnish application. The analysis of 1090 respondents revealed that the main domains driving dental practitioners' (GDPs) decisions to apply varnish were complex and related not only to knowledge but also social/ professional role and identity, social influences and emotion. Within these domains, the decision to apply fluoride varnish was made when that fluoride varnish application was perceived as: advocated in current guidelines; an important part of the GDPs' professional role; something parents want for their children and something GDPs really wanted to do. This suggests that it is not just clinical need that drives the provision of care; practitioners' views of their own role identity and their emotions also have an influence on care and how it is delivered.

#### **Summary points**

- Papers reporting professional perspectives related to the clinical environment focus on skills and training rather than patient experience. There is some evidence to suggest that more education and training is needed in non-clinical skills, such as communication and professionalism. (Gilmour et al 2014, Oliver et al 2016)
- Dentists' role identity and emotions may also influence care decisions. (Gnich et al 2015)

### *4.2.2 The dental team and teamwork*

#### *4.2.2.1 Studies including patient perspectives*

Dental teamwork was highlighted in four publications which featured perspectives from patients (Dyer et al 2010, Dyer et al 2013, Zijlstra-Shaw et al 2013, Chandarana et al 2014). A key feature within these articles was acceptance of teamwork in support of the delivery of dental care. Articles indicated that good use of skill mix and staff interactions were deemed to be an important aspect of dentistry. However, reports suggested that when compared, direct patient interaction and clinical experiences were considered to be more important than teamwork.

In a study, examining the perceptions and acceptability of the roles of members of the dental team, Dyer et al (2010) collected data from telephone surveys with 1000 individuals. They explored the views of adult patients and parents of child patients on the delegation of their care to dental therapists. This study found that some patients felt that delegation was a cost-based decision. This study identified the importance of trust, acceptable behaviour and good communication. In addition, the study highlighted the need for a clear understanding of the roles and responsibilities of all members of the dental team, so that patients had clarity about why a particular team member was providing their care, which was considered an important issue.

In another study by Dyer et al (2013), issues important to patients when their treatment is delegated to a dental therapist were investigated through one-to-one semi-structured interviews. They detected a lack of awareness of the role of therapists amongst patients. Patients' view of skill-mix, trust and familiarity with the delegation of duties within the dental team was related to a high standard of behaviour and communication within the dental team. They found that in relation to patient satisfaction, important attributes

included “good chairside manner” of dentists and the dental team “taking an interest in the patients’ wellbeing”. The authors distinguished a “collectivist” or public service view of dental services (concerned with serving a community) which they contrasted with a more “consumer-oriented” stance or private-service perspective. In the context of high levels of satisfaction with care, consumerist perspectives saw choice of clinician and the costs of care as key issues in skill-mix use. In contrast, public service perspectives appeared to accept a team approach and associated charges with the procedure rather than which clinician was performing the service.

The conceptual model of professionalism developed by Zijlstra-Shaw et al (2013) (on the basis of qualitative study with a range of participants including patients/public) identifies self-awareness and awareness of others (including patients and other members of the dental team) as important.

In their study of ‘what makes a good dentist’, Chandarana & Hill (2014) investigated whether individuals’ requirements of a good dentist reflected the priorities laid out in the GDC (2013) standards for dental professionals. This pilot study included the use of a questionnaire and a focus group capturing data from dental students, graduate dentists and dental patients who frequented a UK dental teaching school. Patients and dentists ranked co-operation with members of the dental team below other professional behaviours such as putting patients’ interests first and being trustworthy.

#### **Summary points**

- The literature suggests that good use of skill mix and teamwork are an important aspect of dentistry. Trust, communication and understanding the roles influence patient perspectives on the delegation of care to dental therapists. (Dyer et al 2010, Dyer et al 2013)
- In contrast to other aspects of care (such as putting the patients’ interests first) teamwork was deemed less important. (Chandarana & Hill 2014)

#### *4.2.2.2 Studies featuring professional perspectives*

Publications which focussed on the professional perspective examined teamwork skills and practice (Morison et al 2011, Ajjawi et al 2017). A further two articles highlighted professionalism issues and failings in respectful relationships with members of the dental team (Steadman et al 2009, Neville et al 2017).

Using a two-stage questionnaire process, Ajjawi et al (2017) sought to determine what dental practice team members believed should be the national “dental education research (DER)” priorities for Scotland for the following two-year period. The importance of teamwork and issues relating to preparedness for practice scored highly across dental professionals, researchers and educators, some of whom were non-dental professionals. Females rated teamwork and professionalism more highly than males. Dental care professionals rated teamwork and professionalism more highly than dentists and non-dental professionals.

Morison et al (2011), conducted a qualitative study with focus groups from a purposive sample of dental and DCP students. They found that professional identity was an important factor in team development and was determined by direct responsibility for patient care and by the amount of clinical experience acquired. Professional identity within a team context was perceived as different from professional identity per se. Students from all professions identified communication skills as having a key role in

effective teamwork and all groups considered that their professional identity developed as they learned to communicate as a dentist, hygienist, dental nurse or technician.

In a study which included 136 hospital dentists in the UK, Steadman et al (2009) found that 25% (n=34) identified themselves as victims of bullying, and 47% (n=63) had witnessed their colleagues being bullied. The study reported that, irrespective of whether they labelled themselves as victims of bullying, 60% (n=82) of dentists had experienced one or more of the bullying behaviours included in the checklist, over the previous year. From an analysis of GDC investigation cases, Neville (2017) identified one case of a professional lapse, whereby team members published derogatory information about a dental colleague online and a further case where inappropriate comments were posted online in relation to NHS staff with religious beliefs.

#### *Discussion and Opinion articles*

Bullock et al (2011), contributed to the skill-mix debate in UK primary care dentistry. On consideration of relevant literature about dental therapists and skill-mix in dentistry they identified factors operating at macro, meso and micro levels and set out the dimensions of seven factors which influenced this: funding focus, the profession's response, workforce, the practice, dentist's knowledge, dental therapist's motivations and patient attitude. The authors suggested a review of these factors could be used to inform policy decisions.

#### **Summary points**

- Teamwork is recognised as important, and in addition to good communication, effective teamwork is influenced by a range of factors operating at the micro, meso and macro levels. (Bullock & Firmstone 2011, Morison et al 2011, Ajjawi et al 2017)
- Problematic teamwork is associated with poor professional behaviours; this is evidenced in the literature through reported incidence of bullying. (Steadman et al 2009, Neville et al 2017)

#### *4.2.3 Safe and clean practice*

Safe practices and a clean and safe environment were highlighted in a number of studies which focussed on professional perspectives. These described professional responsibilities for the environment in which care is delivered to ensure that processes and procedures were in place and were also followed (Taylor & Grey 2015). Studies also described concepts associated with taking responsibility for ensuring sufficient knowledge, knowing the limits of your own competence, and raising concerns when people could be at risk (Gilmour et al 2014).

Using clinical incident reporting, Taylor & Grey (2015) investigated professionalism among dental students. They found that reported behaviours, deemed to be unprofessional, commonly related to endangering the safety of themselves or others, a lack of insight, or lack of respect. They reported that behaviours included failure to fully adhere to dental unit husbandry protocols and sharps safety, potentially endangering themselves or their nurse to a 'sharps' injury.

Hurst (2016), reviewed patient safety in dental settings and identified a number of potentially useful tools (checklists, reporting systems, trigger tools, alerts on electronic notes). However, they also noted the importance of the safety culture of the organisation, the resources available, organisational leadership and anticipating future incidents.

Gilmour et al (2014), investigated the views of dental foundation educators/ trainers about their new graduates' skills. This study indicated that trainers had some concerns about some new graduates being overconfident in their skills and also in their ability to raise concerns when patients were at risk.

#### *Discussion and opinion articles*

Discussion articles focussed on highlighting areas of potential risk to patients. Articles also outlined some of the pressures on practitioners in delivering safe practice. The most commonly described source of ethical conflict was the balance of care and financial pressures on a practitioner (Alani et al 2015, Affleck et al 2017) and at the organisational level (Bagg & Wellbury 2015, Bissell & Felix 2015).

In a joint statement from the specialist dental societies (UK), Alani et al (2015) outlined issues associated with the risks and benefits of cosmetic dentistry. This highlighted the importance of patients being provided with the appropriate description of what a treatment option involves. The authors discuss issues including structural weakening of teeth arising from invasive procedures and adverse outcomes for patients who request cosmetic dental improvements that are preventable by using biologically safer initial approaches to treatment planning and its provision. The ethical challenges associated with the risks of harm related to cosmetic procedures are discussed and the authors describe the importance of considering options to minimise risk and provide information to patients in accordance with the professional duty of candour.

In a discussion paper which explores ethical issues in dentistry, Affleck et al (2017) argued that dental professionals can potentially harm patients and all dental professionals have a responsibility to raise concerns about the behaviour of a colleague or an employer that may be placing patients at risk. They also argued that the remuneration of dental professionals can potentially influence behaviours resulting in patients' interests not coming first. They suggested that a shift towards more salaried dental professionals could reduce potential conflicts of interest and enable greater focus on patient interests.

Organisational financial pressures were considered in discussion articles relating to the Francis Report into the deaths at Mid-Staffordshire NHS Trust (Bagg & Wellbury 2015, Bissell & Felix 2015). These publications highlighted the problems facing the NHS when patients, families, clinicians and nurses are not heard, and where the management, leadership and ensuing culture are focused on the system's business, not patient care. Although the Francis Report reinforced the efforts of senior leaders to prioritise quality of care as equal to, or more important than, financial performance, tension between the two goals remain.

#### **Summary points**

- Provision of a safe environment for care delivery requires that processes and procedures are in place and followed. Tools (such as checklists, reporting systems, trigger tools, alerts on electronic notes) are available that may help but the safety culture of the organisation and leadership are important. (Taylor & Grey 2015, Hurst 2016)
- Ensuring safety also needs knowledge of the limits of competence and raising concerns as appropriate. (Gilmour et al 2014)



- Discussion papers draw attention to ethical conflict between care and financial pressures on a practitioner and at the organisational level. (Alani et al 2015, Bagg & Welbury 2015, Bissell & Felix 2015, Affleck et al 2017)

#### 4.2.4 Time management

Time management, including being able to obtain an appointment, waiting time to see clinicians, and use of time within the context of the care environment, featured within the literature (Tickle et al 2015, Morgan et al 2017, Cope et al 2018). Time was often presented as a precious commodity, and the fact that time constraints could influence patients being treated with fairness and without discrimination. Both these issues were raised as part of patient concerns (Okala et al 2018).

The concept of timeliness and in particular not having to wait for appointments was identified as being important in a study that interviewed over 500 adults in England (Tickle et al 2015). This was further supported by a qualitative study which indicated timeliness and appointment availability was one of the reasons for attending a general medical practitioner for dental problems instead of a dentist (Cope et al 2018).

Issues of inequality and discrimination in relation to being able to secure appointments were raised in one report. In a survey of over 1500 people who were living with HIV, Okala et al (2018) highlighted the importance of being able to secure appointments. They found that time management was an issue for over 12% of patients, who were not given a full range of options for appointments and were often booked in for the last appointment of the day. The authors highlighted issues of inequality in service provision for those living with HIV.

Use of time in the surgery was also reported in the literature. In a further qualitative study of children, Morgan et al (2017) found that patients felt that it was particularly important to spend the time needed to make sure they understood the treatment and what was happening to them.

#### Summary points

- Patient and public views of time management specifically highlighted the availability of dental appointments which affected whether or not they were able to obtain appropriate dental care in a timely manner. (Tickle et al 2015, Cope et al 2018, Okala et al 2018)
- Within the appointment, it was reported that time is needed to explain treatments to children. (Morgan et al 2017)

### 4.3 Interpersonal experience of care and qualities of the clinician

#### 4.3.1 Communication skills, trustworthiness and respect

##### 4.3.1.1 Studies including patient perspectives

Communication skills featured in a number of studies which included patient perspectives and experiences (Zhou et al 2012, Morgan et al 2017). Alongside communication, studies often considered the patient experience of communication which included a sense of trustworthiness and being treated with dignity and respect (Zijlstra-Shaw et al 2013, Chandarana & Hill 2014, Muirhead et al 2014, Mills et al 2015, Cope et al 2018).

In a small qualitative study, which interviewed thirteen children and looked at dental anxiety, Morgan et al (2017), identified communication skills and the qualities of team members as being an important aspect of the care experience. Participants described their experiences of dental anxiety across multiple dimensions (situational factors and altered thoughts, feelings, physical symptoms, and behaviours). Participants placed considerable value on communication by dental professionals, with poor communication having a negative influence on dental anxiety and the dentist–patient relationship.

In an interview-based study looking at patients' initial visits to a dentist, Cope et al (2018) found that how they were treated clinically and personally affected whether the patient returned for continued care. Whilst patients mentioned that they may not be satisfied with the dental procedure undertaken, they had much more concern if they felt that their views were not taken into consideration and if they were not treated in a dignified and respectful manner.

Mills et al (2015), looked at the issue of patients' perceptions of patient-centred care. They used semi-structured interviews with a small number of patients. The authors described five areas of patient-centred care: connection, attitude, communication, empowerment and feeling valued. Being treated with dignity, spoken to in a calm and respectful manner and not being judgemental in their approach were seen as important attributes for a dentist. Patients stressed the need for clear and supportive information to enable them to reach an informed view of all the treatment options. Negative approaches by dentists were seen to result from lack of information, poor communication skills, attitude, failure to listen, use of technical language, poor English language skills or lack of time. Amongst these patients, the authors found a belief that if the dentist acted in a professional and caring manner then they were more likely to provide appropriate treatment which was of a high standard.

Zhou et al (2012), reviewed video recordings of dental nurses' application of fluoride varnish and their behaviour towards pre-school children in Scotland as part of the 'Childsmile' initiative. They concluded that dental nurses worked in a professional way when managing the children. However, they behaved differently depending on whether the procedure had been successful or unsuccessful during the fluoride application sessions. When the procedure had been unsuccessful, dental nurses increased the frequency and duration of the following behaviours: "permission seeking", "offer of task alternative", "information seeking" and "reassurance". In the cases where applications were successful, "praise", "instruction" and "information-giving" were used more frequently and for a longer duration.

Using mouth examinations and completion of a questionnaire, Muirhead (2014) investigated the relationship between 'oral health-related quality of life' (OHRQoL) and oral health. This study highlighted the importance of trust and confidence and found that quality of life measures were reduced with patients in the older age bracket who lacked trust and confidence in their dental practitioner.

In a small pilot study of clinicians and patients, Chandarana & Hill (2014) found that dental students and graduate dentists were in agreement about four of the six attributes of a dentist recorded in the GDC's standards (2013). These included "putting patients' interests first and acting to protect them"; "being trustworthy"; "respecting patients' dignity and choices"; and "maintaining your professional knowledge and competence".

However, the patients' perceptions were different in that they ranked only "putting patients' interests first and acting to protect them" and "respecting patients' dignity and choices" as of importance to them. The authors suggest that further investigation of patients' views is required.

In a qualitative investigation which included patients, Zijlstra-Shaw et al (2013) identified a number of themes including that "professionalism encompasses both tacit and overt personal aspects". Tacit aspects include being trustworthy and being aware of others within different contexts. Overt aspects include "altruism, sense of vocation, responsibility and accountability". Reflection by professionals and self-awareness of their professionalism is a central theme.

#### **Summary points**

- The importance of good communication is evidenced in studies of children where poor communication can negatively affect anxiety and where staff behaviour is found to vary depending on whether the procedure (application of fluoride varnish) was successful or not. (Zhou et al 2012, Morgan et al 2017)
- A sense of trustworthiness and being treated with dignity and respect were also found to be important and when a dentist acts in a caring manner, patients may be more likely to believe their treatment is of a high standard. (Zijlstra-Shaw et al 2013, Chandarana & Hill 2014, Muirhead et al 2014, Mills et al 2015)

#### *4.3.1.2 Studies featuring professional perspectives*

Taylor & Grey (2015), investigated professionalism with dental students using clinical incident reporting. They found professional behaviours predominantly related to altruism and involved helping colleagues, staff and patients. Conversely, incidents relating to a lack of professionalism included a lack of conscientiousness, poor timekeeping, lack of knowledge and a lack of preparation for the planned work. Characteristic of other poor professional behaviours included endangering the safety of themselves or others, a lack of insight, or respect (see also section 2.3).

Using semi-structured interviews with a small number of dentists, Nowak et al (2018) investigated patient-dentist communications. Their findings were based on the dentists' perceptions of their communication with their patients. The authors identified three communication themes relating to "treating the whole person", "barriers to patient-centred communication" and "mutuality of communication". Being polite and respecting patients' needs was deemed essential. The dentists in their study felt that the way they communicated and treated patients was influenced by their patients' requirements. They also highlighted the significant impact that time-constraints can have on the ability to communicate fully with patients.

Rees et al (2015), conducted three individual and 11 group interviews with 69 healthcare students in three Universities to elicit professionalism dilemma narratives. This study identified 79 individual, relational, work and organisational factors contributing to abuse within healthcare education. Students from each of the healthcare groups described those who were deemed perpetrators of abuse as being unprofessional. Behavioural characteristics of those who were considered abusive in the healthcare environment included arrogance, lacking insight, controlling behaviours,

forgetful, difficult, demanding and disorganised. Other issues, associated with perpetrators, were described in terms of emotional or mood related issues, for example being angry, in a bad mood, aggressive or frustrated. Further descriptions included a lack of interpersonal skills (e.g. rude, harsh, poor communication skills, making others feel subordinate and overstepping personal and professional roles); and professional incompetence (e.g. lack of knowledge, lack of understanding).

#### *Discussion and opinion articles*

When investigating the issue of dental anxiety, Ahmed et al (2016) stressed that a clinician who displays empathy with and understanding of a patient's anxiety is more likely to promote a successful and appropriate treatment outcome for their patients.

Zijlstra-Shaw et al (2012) identified and considered a range of aspects of professionalism. These included: altruism, compassion, honesty and integrity, respect and trustworthiness.

Holden (2011) drew attention to how patient communication changes during the transition from being a dental student to transforming into a new graduate dentist working in the primary care environment. The author concluded that dental students feel more able to address a variety of communication issues whilst working in a very supportive environment, where they are not directly influenced by the demands of general dental practice. As foundation dentists they need to be vigilant in their record keeping and in the way they communicate with their patients and with other members of the dental team.

#### **Summary points**

- Approaches such as being polite, respectful and helpful are markers of professional behaviour, along with compassion, integrity and trustworthiness. (Zijlstra-Shaw et al 2012, Taylor & Grey 2015)
- Being empathetic with anxious patients can enhance outcomes. (Ahmed et al 2016)
- The dental professionals' ability to communicate with patients can be affected by the demands of general practice, their patients' requirements, and limited by time-constraints. (Holden et al 2011, Nowak et al 2018)

### *4.3.2 Involving patients in decision-making*

#### *4.3.2.1 Studies including patient perspectives*

The concept of patient autonomy has been identified within the literature. Studies involving patients have often focussed on empowerment, being given information and choice. For example, Morgan et al (2017) in a small interview-based study investigating dental anxiety in children aged 11-16, found that young patients wanted to be involved in decisions about their care.

#### **Summary point**

- Patients, including young people, desire to be given information to facilitate their involvement with decision-making about their treatment and care. (Morgan et al 2017)

#### 4.3.2.2 Studies featuring professional perspectives

Nowak et al (2018), concluded from their study of patient-dentist communications using semi-structured interviews with dentists, that the best way to make the relationship between dentists and their patients work is to ensure that the dentist strives to involve their patients in the decision-making process and that patients take ownership and responsibility for the maintenance of good oral health.

##### **Summary point**

- Involving patients in the decision-making process enhances relationships between patient-dentist. (Nowak et al 2018)

##### *Discussion and opinion articles*

Discussion articles and commentaries focussed on professional responsibilities for supporting patient autonomy and decision making for consent (Muschik & Kallow 2015, O'Keefe 2015, Burke et al 2017a, 2017b). While most of the literature focussed on dental professionals and their responsibilities, two publications considered the influence of advertising and the media on treatment decisions which potentially generate unrealistic expectations of dental care (Alani et al 2015, Holden et al 2019). A further article which provided a young dentist's perspective outlined the stress and wellbeing issues for dental professionals when patients' expectations were not met (Al Hassan et al 2017). One opinion paper suggests the need to enhance the evidence base related to sharing treatment options with patients (Sellars & Wassif 2019).

Burke et al (2017a, 2017b), in commentaries on consent and capacity and how this relates to members of the dental team, stress the importance of patient autonomy and the importance of the dental team ensuring that they provide full information and support their patients' (and where relevant their carers') understanding and ability to make informed decisions about their own treatment. This is equally important where patients' views do not accord with what their clinician believes is in their best interests, so that they are fully aware of the consequences of the actions that they take.

Muschik & Kallow (2015), in a discussion article, considered how dental phobia in patients could affect practitioners' ability to truly provide informed consent for treatment. They concluded that "informed consent is an ethical and legal principle that protects patients' rights to make autonomous decisions about their treatment" and that dental phobia can significantly influence a patient's ability to provide informed consent. This was highlighted as a challenge for dental professionals who have a legal and ethical duty to promote and support patients when dealing with informed consent.

O'Keefe (2015), reviewed communication skills for dental nurses with extended skills and highlights the relevance of effective communication in the GDC's 'standards for the dental team' (2013), a principle that stresses the importance of making sure that patients "receive clear and accurate information in a way that they can understand and be in a position to make an informed decision".

In an opinion paper, Sellars & Wassif (2019) explored evidence-based dentistry using an ethical framework. They stressed the need for evidence that treatment options were shared with patients so that they could make an informed decision on their care. As part of this process it is important to prove the beneficial nature of the options that are

available. The authors felt that dentistry lagged behind medicine and was less advanced with regard to research into the evidence base of the important aspects of sharing treatment options with patients.

Alani et al (2015) presented a joint statement from the specialist dental societies (UK) on the risks and benefits of dental cosmetic treatment. They stated the importance of patients being provided with the appropriate description of what a treatment option involves and that patient pressure to have what they want should not overshadow appropriate clinical care.

Patient demands can be influenced by programmes such as ‘Embarrassing Bodies’ which Holden et al (2019) suggests focuses disproportionately upon restorative dental interventions, especially cosmetic dental therapies, in preference to preventative treatment. The lack of preventative focus in these cases may falsely suggest that these treatments are a quick and simple solution to oral disease, rather than as the endpoint of a long-term rehabilitative oral health plan. The authors also argue that the patient-clinician relationship is misrepresented as one in which the power lies disproportionately with the dentist. This, they suggest, is at odds with the reality of a more equal relationship.

The potential influence of costs and remunerations systems on decisions were considered in an opinion paper. Affleck et al (2013), highlighted the challenge of remuneration systems which they suggest can disincentivise decisions which are in the best interests of patients. The authors highlighted the need to balance the clinical and financial aspects of dental care when making decision about patient care appropriately in relation to professionals’ funding and in relation to how professionals act outwith their working/clinical environment.

Al Hassan (2017), in a commentary from the perspective of a dental student, highlighted wider challenges of learning the business side of general practice in relation to the NHS and private systems, and working within a litigious environment. The article suggests that many young dentists feel vulnerable and stressed by overzealous complaints and overarching regulatory and financial issues. Such pressures were seen to lead to defensive practice and potentially poorer outcomes for patients.

#### **Summary points**

- Informed decision-making and consent are widely discussed in opinion pieces and commentaries. Involving the patients in decision-making is recognised as involving two-way communication. (Muschik & Kallow 2015, O’Keefe 2015, Burke et al 2017a, 2017b)
- Dentists are encouraged to make decisions in the best interests of the patient but there are many challenges in this process which include financial disincentives and patient expectations and challenging working environments. (Affleck et al 2013, Alani et al 2015, Al Hassan et al 2017, Holden et al 2019)
- Patient choice is considered to be important for care (Sellars & Wassif 2019) but advertising and the media can influence patient expectations and generate unrealistic demands (Alani et al 2015, Holden et al 2019) and contribute to young dentists feeling stressed. (Al Hassan et al 2017, Holden et al 2019)

#### *4.3.3 Professional appearance*

Professional dress and appearance are considered to be a part of professionalism. Studies which have included public and/or patient perspectives indicate that traditional dental attire is valued by patients (Mistry et al 2009, Furnham et al 2013). Studies of dental professionals have similar findings, but it was suggested that traditional uniforms may reinforce a sense of hierarchy in the dental team (Morison et al 2011).

##### *4.3.3.1 Studies including patient perspectives*

Using photographs, Furnham et al (2013) investigated the public's perception on whether what dental and law professionals wore related to their views on how professional they were. The results showed that this cohort of the public believed both professionals to be more able, friendlier and easier to converse with when they were males who were dressed in professional and formal clothing. They preferred professionals who wore a white coat or a formal dark suit over those who wore less formal attire. It was concluded that this formality of attire would strengthen long-term client/patient/professional relationships which in turn might improve outcomes for the client/patient.

In a study by Mistry & Tahmassebi (2009), parents and their children were asked to complete a questionnaire about dentist and student attire using a series of photographs. Parents preferred clinicians to be in formal attire, such as in a white coat or wearing a suit with an appropriate shirt and tie. Children however, preferred a more casual attire. It was concluded that appearance does make a difference to patients' perceptions of clinicians' professionalism and how at ease and receptive to treatment they felt.

##### *4.3.3.2 Studies featuring professional perspectives*

Morrison et al (2011), utilised focus groups to investigate perceptions of the roles and status of different members of the dental team. Both dental students and dental hygiene students believed that the type of attire they wear is a symbol of their identity as professionals. Dental students feel that wearing a formal attire engenders respect from other dental team members, but hygiene students felt that this defined a reduced status for them within the dental team.

#### **Summary points**

- Dress and appearance influence patients' perspectives of the clinician's professionalism and how at ease and receptive to treatment they feel. Traditional dental attire is valued by patients, although children may prefer more casual attire. (Mistry et al 2009, Furnham et al 2013)
- Studies of dental professionals suggest that clothing is a symbol of professional identity but that traditional uniforms may reinforce a sense of hierarchy in the dental team. (Morison et al 2011)

#### *4.3.4 The influence of costs and remuneration*

The financial aspects of dental care have been considered in the professionalism literature.

##### *4.3.4.1 Studies including patient perspectives*

Studies featuring the patient perspective on costs of care and value for money indicate how these influence care seeking behaviour and perceptions of care. Tickle et al (2015), in a survey of the public in England (described earlier), identified that the cost of care and value for money were important to patients. Of study respondents who felt the quality of their care was poor, 82% also thought the service was poor value for their



money. Cope et al (2018), as described previously, also considered willingness to pay during interviews with patients and found that costs affected care seeking behaviours.

#### *4.3.4.2 Studies featuring professional perspectives*

Studies, from a professional perspective, have focussed on remuneration systems and their influences on dentists' clinical behaviours (Chalkley et al 2010, Brocklehurst et al 2013, Harris & Holt 2013).

In a systematic review, Brocklehurst et al (2013) investigated remuneration and its effect on primary care dentists' behaviour. They highlighted that as dental practices are businesses, professional behaviour can be influenced where there may be a perceived conflict between service provision and the risks associated with financial remuneration. The review included two studies: the first found an increase in clinical activity related to fee-for-service payments; in the second study, dentists working under capitation arrangements restored carious teeth at a later stage in the disease process than fee-for-service controls. The study concluded that financial incentives within remuneration systems may produce changes to clinical activity undertaken by primary care dentists. The authors recommended further investigations to review the interaction between financial remuneration, clinical service provision and the outcome for patients.

In a qualitative study which included 11 associate dentists working in primary care, O'Selmo et al (2019) identified three main themes related to "conditions" (how associates viewed their working environment), "drivers" (in terms of what associates believe drives their working conditions) and "effects" (how associates are affected by their working environment). Responses from associates working in corporates were different when compared to those working in environments of general and independent practice. Key issues concerned decision-making and finances. The current NHS contract and the pressure to balance patient need and the units of dental activity (UDA) system were challenging. This professional versus business conflict manifested in many ways and some associates were asked to upsell or push treatments they felt were inappropriate. Corporate and independent dental associates reported enjoying their jobs but at the same time, many experienced feelings of overload, stress and being undervalued by others.

Chalkley et al (2010) reported on data derived from a natural experiment in the UK publicly funded dental care system which looked at dentists' remuneration in relation to clinical activity. They found that dentists who moved from quasi-employment to an activity-based incentive contract increased their activity in the publicly funded service by 26%. The authors suggested that contractual arrangements with explicit rewards influenced service provision and that an individual's intrinsic motivation, professional standards, and preferences were important moderators of financial incentives.

In an analysis of archival literature and policy documents, interview data and service delivery data from 16 English dental practices, Harris & Holt (2013) found two logics dominating how care is assessed: business-like health care and medical professionalism. This study highlighted the distinction between business-like health care logic, distinguished by values of commercialism, and the logic of professionalism, distinguished by commitment to clinical expertise and independence in delivering patient care.



### *Discussion and opinion articles*

Discussion articles have considered the ethics, conflicts and challenges of care in the light of the financial challenges (Singh et al 2009, Trathen and Gallagher 2009, Ahmad et al 2010, Affleck et al 2013, Alani et al 2015).

Trathen and Gallagher (2009), in their opinion paper discuss ethics and its role in the foundations of professionalism. They highlight the challenges involved in balancing the demands of patients, where there may be a significant financial incentive to the clinician, with carrying out the appropriate care and thus maintaining high professional standards. They proposed a definition for professionalism and a framework for debate in which patients' interests are at the heart of the practice of dentistry.

How remuneration of dental professionals can potentially influence behaviours resulting in patients' interests not coming first has been reported earlier (Affleck et al 2013). The authors suggested that potential conflicts of interest are reduced for salaried dental professionals.

Ahmad (2010), reviewed the ethical issues in relation to cosmetic/aesthetic dentistry. The article recognised that in preparing a treatment plan, the clinician has to balance the professional approach which includes patient education, respect for what they want and the evidence-base for the treatment approach. The author concludes that a patient's health should take precedence over their wishes and that the ethical approach should never be overshadowed by financial implications. This echoes findings, reported earlier, by Alani et al (2015).

In a review of the GDC's professional conduct committee's cases over a five-year period (2003-07), Singh et al (2009) noted that most cases involved more than one type of issue and two of the most frequently recorded professional issues were NHS fraud and dishonesty. They concluded that the increase in the number of cases reflected that the GDC were taking professional conduct seriously.

#### **Summary points**

- Patients' care seeking behaviour and perceptions of care can be influenced by costs and value for money. (Tickle et al 2015, Cope et al 2018)
- Remuneration systems can influence clinical behaviour, although financial influence is only one element in a complex mix of influences and ways of thinking. (Chalkley et al 2010, Brocklehurst et al 2013, Harris & Holt 2013)
- Although working in the best interests of the patient is a central pillar of professionalism, conflicts of interest may arise from patient demands and financial incentives (Trathen & Gallagher 2009, Ahmad et al 2010, Affleck et al 2013, Alani et al 2015)
- Cases of fraud and dishonesty are common in cases of professional misconduct. (Singh et al 2009)

### *4.3.5 Interpersonal experience of care and qualities of the clinician: evidence from the wider literature*

Patient experiences have been reflected in the wider health and care literature. Bastemeije et al (2017), undertook a systematic review of qualitative papers on what patients value. A final sample of 22 studies met the inclusion criteria. Following analysis, the authors identified seven key elements reflecting patient values: uniqueness,

autonomy, compassion, professionalism, responsiveness, partnership and empowerment. These were further categorised into three themes. The first theme described values related to the patient and their personal context. This category had two subthemes which recognised the uniqueness of the patient and secondly their autonomy. The second category described the characteristics of the professional that are valued by the patient; this category had three subthemes which were compassion, professionalism and the responsiveness of the professional. The final theme was interactions between the patient and professional, of which partnership and empowerment were the main subthemes. The authors described how patients value attentiveness and human interest and a caring, honest, reassuring professional, who inspires trust. Compassion was identified as a particularly important attribute alongside communication skills.

A systematic review of patients' experiences before surgery was reported by Chan et al (2012). This included 11 studies. The authors identified four main themes relating to patients' experiences of preoperative communication with healthcare professionals: need for information, involving relatives, need for control and healthcare professionalism. They concluded that patient descriptions reflected a range of different needs and desires in relation to communication. They found that patients' perceptions of whether or not these needs are met affected the outcomes of surgery. They concluded that healthcare professions need to place a greater emphasis on individualised communication to meet patient needs.

Panagioti et al (2018), conducted a systematic review and meta-analysis to examine associations between physician burnout and the quality and safety of healthcare delivery. This included 47 studies of 42,473 physicians working in any healthcare setting. Most of the included studies used similar established tools to measure burnout. Lower quality and unsafe care were measured by patient safety incidents, poorer care outcomes as a result of low professionalism, and lower patient satisfaction. The authors found that "physician burnout was associated with an increased risk of patient safety incidents (OR, 1.96; 95% CI, 1.59-2.40), poorer quality of care due to low professionalism (OR, 2.31; 95% CI, 1.87-2.85), and reduced patient satisfaction (OR, 2.28; 95% CI, 1.42-3.68)". The heterogeneity was high, and the qualities of the studies was low to moderate. The links between burnout and low professionalism were larger in residents and early-career physicians ( $\leq 5$  years post residency) compared with middle- and late-career physicians (Cohen  $Q = 7.27$ ;  $P = .003$ ). The association between burnout and poor professionalism was particularly strong among studies based on residents and early career physicians.

Thirty-two articles were included in a review which explored bullying, undermining behaviour and harassment (BUBH) in surgery (Halim & Riding 2018). Of these, 22 reported the prevalence of BUBH in surgery, 11 studied the impact of BUBH behaviour and six investigated counterstrategies for managing this. They found that BUBH was common in the surgical workplace with a profound impact on mental health and job satisfaction and could induce suicidal thoughts. Reporting systems were considered to be ineffective and even potentially harmful. They also reported that there were few studies showing which counterstrategies were effective but did suggest that professionalism training with simulated scenarios may be of some use.

**Summary points**

- Themes in the dental literature on patient perspectives of professionalism particularly in relation to interpersonal experiences, traits of professionals and communication skills echo those seen in the wider healthcare literature. (Bastemeije et al 2017, Chan et al 2012)
- Patient autonomy and experience appear throughout the literature.
- There appears to be less focus on the financial conflicts of care in the wider healthcare literature.
- Issues of clinician burnout and the effects on patient experience and care feature in the healthcare literature but have received less attention in the dental literature.
- Studies indicate that bullying and harassment are an issue in healthcare, with significant effects on wellbeing but there is little evidence to show how to address this. (Halim & Riding 2018).

#### 4.4 Professional-personal divide and social media

The behaviour of dental professionals outside the dental surgery featured in a range of articles, with many focussing on social media (Kenny & Johnson 2016, Neville et al 2017, Parmar et al 2018). These articles explored patient and professional perspectives on behaviours outside of work.

##### *4.4.1 Studies including patient perspectives*

Parmar et al (2018), reported data from an online survey of patients and dental professionals on their views about the use of social media. The study found that 73% (374/511) of patients did not expect their dental practice to have a social media presence but 36% (164/460) of patients had searched for their dentist online and were interested in exploring additional information such as online reviews and the qualifications of their dentists on Facebook pages. With regards to appropriate behaviours, 44% (207/468) of patients surveyed thought that establishing a friendship with their dentists was not appropriate, but 44% (207/470) were happy to establish contacts with dentists on social media. This contrasted with 74% (333/448) of dentists who agreed that social media friendship was not appropriate.

##### *4.4.2 Studies featuring professional perspectives*

Using a questionnaire, Kenny & Johnson (2016) investigated dental students' use of social media and their attitudes, behaviours and perceptions of professionalism. Respondents were provided with a range of scenarios and indicated how professional/unprofessional they felt the behaviours were. The majority (92%) of respondents indicated that publishing images of intoxicated students was unprofessional. Two thirds of respondents (n=99, 64%) reported that publishing photographs, online, of students drinking alcohol was also unprofessional. One third of students rated posting anonymised dental procedures as unprofessional (n=50, 32%); and over two thirds of students had seen this online. The authors stated that "the majority of students rated using open and public groups to discuss patients, staff or other students, interactions with patients via social media and making negative comments regarding people's characteristics as unprofessional".

Dobson et al (2019), in a study of dental students, found that they expressed a range of views with regard to photographs of themselves in compromising situations outside of the workplace. The authors drew attention to the distinction between being seen consuming alcohol and being seen in the company of friends drinking alcohol but warned that, "the public may assume guilt by association". Students agreed that it is

unprofessional to share any posting about staff/ employers, colleagues and patients. They agreed that 'friend requests' from a patient should not be accepted and they would not allow their own photographs to be posted without their permission. There was less agreement across student years with regard to posting photographs of themselves in the workplace and of their working colleagues.

In a documentary analysis of GDC FtP cases related to non-compliance with the GDC's guidelines on social media, Neville (2017) reported that there the number of cases was small and most complaints related to inappropriate comments posted on Facebook by a dental professional group. Taken in the context that FtP processes and procedures may not reach everyone and therefore not address the probable cases that are unreported, the author suggested that the regulatory body and educational organisations should raise awareness amongst dental professionals and provide more guidance and educational opportunities through continuing education and training for them to keep up-to-date about issues related to use of social media platforms.

#### *Discussion and opinion articles*

Discussion articles also considered the extent to which professionalism should be applied to the personal lives of professionals when this did not affect the care of patients (Neville & Waylen 2015, Affleck & Macnish 2016, Holden 2017).

In an opinion paper, Affleck and Macnish (2016) concluded that the "GDC should not judge individual professionals on the basis of public perception of the profession's reputation" rather that the judgement should relate to "the manner in which a professional treats their patients". The authors discuss a GDC case relating to offensive comments posted online by a dental registrant. They argued that although the comment was offensive and contravened current standards, a key question in the process should have been whether the registrant treated all their patients with respect and appropriate care. This report highlighted the professional-personal divide and the relevance to patient care of dental professionals' behaviour outside work.

Focused on whether social media relates only to private/social aspects of an individual's private life, Holden (2017) questioned whether behaviours and actions outside the workplace affect performance and behavior in the workplace. The author concluded that there is a need:

*to account for the changes living in a digital world means for our interpretations of privacy; nothing we do or post on social media is truly private and we must be careful to foster ideas of e-professionalism.... Professionals are entitled to a private life, but if this is incompatible with our professional role and public exposure would compromise this, we must question whether such behaviour is acceptable even if we are not involved in patient care at that time.*

Neville and Waylen (2015) considered options for social media to support dental professionalism in clinical dental practice as well as identifying areas to be cautious about. Strengthening awareness about social media should aim to protect the individual's reputation, protect professions and protect the wider public. Alerting dental professionals to stand back for a minute and reflect on the implications of what they are about to do (post photographs or comments or use twitter) would be beneficial.

#### Summary points

- Notable numbers of patients look for information (qualifications, reviews) online about their dentist. (Parmar et al 2018)
- Opinion is divided on what is unprofessional use of social media outside the workplace and how this should reflect on in-work professionalism. Some argue that judgement of professionalism should focus on patient care. (Affleck & Macnish 2016) Whereas others suggest that where public exposure of such behaviour comprises the professional role, it is unacceptable even outside the workplace. (Holden 2017).
- Fewer dentists than patients think social media friendship is appropriate. (Parmar et al 2018)
- Dental students identify posting of images on social media of students intoxicated or drinking alcohol or discussing interactions with patients as unprofessional behaviours. (Kenny & Johnson 2016)
- Few GDC fitness to practise cases relate to social media although this does not account for unreported cases or university fitness to practise processes. (Neville 2017)
- Studies have identified concerns about information on social media resulting in the public assuming “guilt by association”. (Dobson et al 2019)
- Dental professionals may need more support around social media use for learning for promoting their practices and learning. (Neville & Waylen 2015)

#### 4.4.3 Professional-personal divide and social media: evidence from the wider literature

Bennet et al (2018), conducted a systematic review of the literature under the premise that guidelines articulating the boundaries of professional use of social media “are nonspecific”. Their final sample included 36 articles. The articles reviewed included a range of recommendations in relation to professionalism on social media. The authors used the findings to develop a list of recommendations which related to patient confidentiality, consent and content for online material. They concluded that “social media continues to be a domain with potential professional pitfalls. Appropriate use of social media must extend beyond obtaining consent, and we must adhere to a standard of professionalism far surpassing that of today's media culture.”

Borgmann et al (2018), report an evidence synthesis in relation to social media use. A total of 12 studies were included for analysis. Stakeholders then used the evidence to develop a list of 10 recommendations for practice:

- *Understand how other users behave online before interacting on social networks*
- *Establish and maintain a professional digital identity that is in line with your professional practice and goals*
- *Never undermine your patients’ privacy or confidentiality*
- *Avoid providing medical advice and maintain limits between yourself and patients*
- *Assume that anything and everything you post is permanent*
- *Use Instant Messaging services with care*
- *Exercise professionalism*
- *Beware of social media policies set by employers*
- *Beware of how advertisement and self-promotion will be perceived by others*
- *Use disease-specific ontology hashtags for structured online communication.*

#### Summary points

- There is general consensus that guidelines are needed for healthcare professionals in relation to social media.
- Areas of concern and risk include patient confidentiality and maintaining a professional image.

## 4.5 Teaching and Education

The teaching and education literature covered a range of themes, which included: student characteristics and attitudes; teaching and learning approaches; role models and identity; curricula and the hidden curriculum; assessment; values and social media. Most of the literature relating to dental education focusses on undergraduates.

### 4.5.1 Student characteristics and attitudes

#### 4.5.1.2 Studies featuring professional perspectives

Focused on individuals aspiring to enter a dental undergraduate training programme, Kay et al (2010) reviewed desirable attributes using a framework which included: communication with patients, communication with staff, sensitivity to others, ethical behaviour, judgement and analysis, management of people, conscientiousness, professionalism, life-long learning, and clinical, academic and technical competence. They concluded that a structured and objective interview based on these non-clinical skills identified in the previous literature, could be a valuable method of recruiting future dental professionals with good non-clinical/professional abilities at the start of their dental career.

Faulks et al (2018), undertook the development and preliminary validation of a battery of tests to assess different aspects of student values, attitudes, intentions and behaviours with regard to people with disability and those in marginalised groups. These included, integrity, defined as “the quality of being honest and of adhering to strong moral principles”, and altruism, which was defined as “the principle or practice of unselfish concern for the welfare of others”. In terms of Special Care Dentistry, these values were deemed to include the belief in health care as a universal human right. In addition, this study also considered that perceptions of professional duty and awareness of the barriers to healthcare contributed to attitudes towards people with a disability and marginalised groups.

Student attitudes can influence learning and in their study of ‘what makes a good dentist’, Chandarana & Hill (2014) report that dental students prioritised manual dexterity over and above professional skills and care, suggesting that students may be less aware of, or may put less value on the importance of the “softer skills” and professional issues in dentistry. Given that adult learning theory recognises the involvement of learners in setting their learning agenda, with students engaging with content that they deem to be important, lack of priority in relation to professionalism may influence students’ engagement and learning in this area. The lack of a perceived need for more professionalism teaching amongst some undergraduates was also reflected in a study of graduates by Oliver et al (2016). They found that a number of recent graduates who responded to their survey indicated learning ‘enough’ or ‘a lot’ in relation to non-clinical topics such as complaints handling in their undergraduate education. The need to learn more may relate to exposure to and responsibility for dealing with real world problems. Established practitioners who were more likely to have encountered these

issues during their working life, reported that they wished they had learned more complaints handling and other non-clinical aspects of dental practice during their undergraduate training.

#### **Summary points**

- Positive professional characteristics and attitudes of students are regarded as being important for dentistry but the extent to which these characteristics are innate or are learned and developed is unclear. (Kay et al 2010, Faulks et al 2018)
- There are arguments for using admissions procedures and interviews designed to select students for dentistry who demonstrate “desirable” attributes. (Kay et al 2010)
- There appears to be a greater sense of needing to learn about professionalism topics at a postgraduate level, with undergraduates, reporting that clinical skills are more important. (Chandarana & Hill 2014, Oliver et al 2016)

### *4.5.2 Teaching and learning approaches*

#### *4.5.2.1 Studies featuring professional perspectives*

Field et al (2010), reported a straw poll of UK dental schools as a basis for understanding the current methods of teaching and assessing professionalism. All respondent schools recognised the importance of professionalism and reported that this was taught and assessed within their curriculum. For most, the methods involved were largely traditional, relying on lectures and seminars throughout the course. The most common form of assessment was by grading and providing formative feedback after a clinical encounter. No single approach was identified as being the most appropriate or successful.

#### *4.5.2.2 Learning environments: clinical encounters, incidents, dilemmas, role models, the hidden curriculum and identity formation*

There are a variety of environments in which professionalism is learned. McHarg and Kay (2009), described the formal curriculum as being influenced by the values of those developing it. They also considered that while there is an intentional learning environment and curriculum, there is also a ‘hidden curriculum’ of things that are learned through those environments which are not part of the formal curriculum. Their article concluded that the attributes required within the curriculum in dentistry “can only be determined through analysis of the past, current, and future health needs, and via knowledge of the different domains of learning, and how these relate to dentistry and to relevant learning activities”. They recognised the value of the spiral curriculum, which increases the depth of student learning at each ‘visit’ to a topic. They also highlighted the need for the formal and hidden curriculum to have the same direction for learning.

Recognising that the professionalism theme should be at the centre of an undergraduate curriculum in dentistry, Beattie et al (2012) explored the issue of empathy in dental students in their first undergraduate year. Using a questionnaire, they reviewed the changes in empathy of students in their first year at a UK dental school, prior to and following “early analytical exposure to behavioural sciences and the clinical encounter”. They reported that first year dental students displayed a statistically significant increase in empathy, supporting their development as professionals, which clearly endorses the concept of early patient contact. The authors recognise the value of role play, observing and acting out real life situations in small groups and observing their senior peers and educators and how they interact with their patients. Boiko et al (2011), investigated the

application of a process known as ‘form analysis’, previously applied within the field of medicine, which involved the observation of five dental practitioners’ encounters with 20 of their patients. Form analysis was considered to be a valuable tool for assessing communication between patients and their dental professional, from which the latter could learn through reflection on their performance during patient encounters.

Taylor and Grey (2015), investigated the value of clinical incident reporting of professional behaviours and attitudes, within a teaching setting. The authors advocated the use of the reports of clinical incidents as a learning opportunity which can be used for reflection and for assessment purposes. They argued that incident reports were a useful tool for learning providing a wealth and variety of scenarios and opportunities for behavioural changes throughout the undergraduate training programme. Such reports have the advantage of being able to be used with a large number of assessors, through a longitudinal process with the minimum of administrative backup.

Monrouxe et al (2015), explored professionalism narratives in a qualitative study of healthcare students which included dentists. Dilemmas experienced by students included: “student abuse”, “patient safety” concerns, “dignity breaches”, “whistleblowing and challenging” and “consent”. The authors concluded that these experiences had implications for interprofessional learning whereby students from health professions could share experiences and learn through narratives. They suggested that role-playing of idealised actions (how students wish they had acted) could also facilitate support and learning.

Through focus groups with dental students, Ranauta et al (2018) investigated what influenced the students’ views about professionalism within the dental undergraduate curriculum. Students highlighted the following learning experiences as influential: “planned teaching of facets of professionalism; experiencing powerful emotions triggered by clinical work; and role modelling in clinical environments”. Students reportedly valued formal planned teaching, which underpinned their learning. Experiences relating to clinical situations were considered to be of greatest value for their understanding of professionalism and learning. They gave rise to a range of emotions associated with their sense of responsibility for care. Some of the real-life clinical experiences were emotionally challenging, triggering strong emotions. Both positive and negative experiences were of significant value, when negative experiences could be refocussed to support learner development. Learning experiences were strengthened through personal reflection and when the clinical situations had planned professionalism issues incorporated into them. Students in this study also emphasised the importance of tutors as role models, but they described variable quality. The authors concluded that “dental schools could support students’ developing understanding and enactment of professionalism by: anticipating and embracing the unpredictability of situated learning in clinical environments; providing opportunities for role models to understand their influence and increase their expertise; paying more attention to the emotional components of learning and the influence of individual biographies; and anticipating the occurrence of negative experiences and supporting students’ reframing of these”.

Morison et al (2011), carried out focus groups with dental and DCP students. Professional roles and identity were central to the study findings. The authors argued that although interprofessional education may be challenging, it can play an important role in helping to prepare dental and DCP students for team practice. A well-designed, purposeful interprofessional workshop is a valuable way to facilitate the early stages of



group interaction. Furthermore, they suggested that curricula should be designed to facilitate the development of a team identity and team leadership skills. This study suggested that the teaching environment, teachers and interactions contributed to professional identity during their student learning. This strong sense of identity was derived from tutor role models, previous clinical experience as dental nurses and from their perceptions of their place in the team hierarchy (inextricably related to their responsibility for patient care).

Professional self-identity formation amongst medical and dental students was explored, by Vivekananda-Schmidt et al (2015), in a mixed methods study. They found that students learned and developed this through opportunities to participate in the professional role, through recognition from others as a quasi-professional in that role and through their extra-curricular activities.

Neville et al (2018) investigated students' responses to the introduction of a 'Dental Scrubs Ceremony' as part of the formal curriculum for professionalism in a dental school. The 'Dental Scrubs Ceremony' involved a two-hour interactive seminar with four topics: an introduction to dental professionalism, an outline of the student code of conduct, discussion of social media and its implications for professionalism, and a review of the dress policy of the local NHS Hospital Trust. Students signed a code of conduct and received their dental scrubs. Students found this to be a positive experience. This was however considered to be a "weak vehicle for teaching professionalism" and the authors argued the purpose was for this to act as "a trigger event, raising students' awareness of their impending role change".

A continuing professional development package on coping skills and resilience was evaluated by Chapman et al (2017). Dentists used two versions of the package: self-help and guided self-help. Results from the small sample included in the study, 35 primary care dentists, showed significant improvements in depression, anxiety, stress burnout and hypervigilant decision making at six months.

#### *4.5.2.3 Studies focused on social media*

Kenny & Johnson's (2016), study of dental students use of social media, attitudes, behaviours and perceptions of professionalism highlights the need for social media training for all dental undergraduates, as social media use is widespread. This training should include awareness and practical training in using professional standards, selecting appropriate behaviours, and managing professional risks online. It is recommended that further work is undertaken to explore the gaps between knowledge of appropriate professional behaviour online, online risks and actual behaviour in order to inform this training. Furthermore, additional work is also needed to examine the most effective way of teaching students to remain professional online. Similarly, the conclusions of Dobson et al (2019) in their study of dental students' knowledge of the GDC's guidelines on social media, concluded that it is valuable to provide education about social media and online professionalism in its widest context, stressing the importance of employing vigilance and reflection on how they use this modern and evolving method of communication. Furthermore, in their study of Facebook use with dental students, Nason et al (2018) suggested that dental schools should consider how they educate their students in the use of social media.

### *Discussion and opinion articles*

Patrick (2017), reviewed the teaching of ethics in undergraduate dental educational curricula. The author suggests “that much curricula content is based solely on a professional governing body’s perspective on the definition of what constitutes the ethical ‘rules’ of practice’ and ‘that ethical education needs to address both skills and ethical analysis in order to adequately equip future dental professionals”. The author argues that in order to be an “ethical dentist” it is important to place the patient at the forefront of a teaching programme and stress the importance of reflection on the activities or actions that a professional undertakes. There is lack of clarity as to whether ethics and professionalism are intertwined or whether it is necessary to demonstrate professionalism in order to provide the “practical delivery of ethics”. In addition, the author refers to the GDC standards (2013) where ethics goes hand-in-hand with legal issues as a subsection of professionalism. Placing the patient at the centre is not considered an ethical issue but rather relates to professionalism.

Furthermore, Patrick (2017) suggests that workshops, problem based learning and small group tutorials have to a certain extent addressed the deficiencies of the didactic approach to the teaching of ethics. Opportunities to relate the teaching of ethics to the student addressed through real-life situations or scenarios using avenues such as journal clubs, reflective practice, storytelling, case-based discussions and work-based scenarios can stimulate students and increase the relevance to clinical and professional practice. In addition, “the use of examined reflective journals or clinical staff assessing student–patient interaction and looking for key appropriate behaviours as part of the consultation embed ethics instruction and assessment into the clinical context”.

#### **Summary points**

- No one approach is considered to be the most effective or successful for teaching professionalism. (Field et al 2010)
- Professionalism teaching and learning curricula are considered to be important. (Beattie et al 2012) Learning is achieved through the formal and hidden curricula and these need to be well aligned for learning. (McHarg & Kay 2009, Beattie et al 2012)
- Studies show that teaching that uses learning from emotionally challenging events, incidents and narratives of dilemmas can support student learning. (Monrouxe et al 2015, Taylor & Grey 2015, Ranauta et al 2018).
- Studies have identified positive role models and professional identities as having a significant influence on professional development. (Morison et al 2011, Vivekananda-Schmidt et al 2015)
- Social media is widely used by students and this is recognised as a risk to students’ professional standing. (Kenny & Johnson 2016, Nason et al 2018, Dobson et al 2019)

#### **4.5.2.3 Curricula**

Formal curricula are important in that they underpin professional learning (Ranauta et al 2018). The Association for Dental Education in Europe (ADEE) in its publication entitled ‘Profiles and Competencies of the European Graduate Dentist’ describe professionalism as “a competence that includes professional attitude and behaviour along with ethics and jurisprudence” (Cowpe et al 2010, Foster Page et al 2016). Neville et al (2018), refer to the more recent publication by ADEE, entitled ‘The Graduating Dentist’ where professionalism is the first domain of four. Within this domain they highlight three “key competences” which contributed to the area of professionalism, namely: “ethics, regulation and professional behaviour” (Zijlstra-Shaw et al 2012, Field et al 2017, McLoughlin et al 2017). Furthermore, when investigating the processes of assessing

professionalism in dental education, it is highlighted that within the ADEE key competence of professional behaviour the following areas contribute to professionalism:

- *appropriate behaviour towards patients and towards all the members of the dental team,*
- *knowledge of the social and psychological issues relevant to the care of patients,*
- *ability to manage and maintain a safe working environment and knowledge,*
- *awareness of the impact of the dentist's own health on the ability to practice dentistry,*
- *the need for continued professional development and education*

A similar approach has been demonstrated by the Committee of Postgraduate Dental Deans and Directors (COPDEND UK) in their 'Curriculum for UK Dental Foundation Programme Training' (2015). The curriculum includes an ethical approach, and the relationships and interactions between the different personnel, including patients, peers and members of the dental team. Bullock et al (2010), produced guidelines for dental educators. One of the seven domains is "professionalism", but it was stressed that professionalism is relevant across all the other domains.

Whilst there is general agreement in terms of what should be covered, those involved in education and training recognise the multifactorial nature and complexity of providing learning opportunities in professionalism within training programmes (Neville et al 2018).

Using semi-structured interviews and focus groups, Ali et al (2016) investigated stakeholder perceptions of a new dental school's curriculum (Peninsula, UK) designed to be "problem-based, student-led and patient centred". Stakeholders included undergraduate and postgraduate trainees, educators, practicing dentists and training programme managers. One of the main curriculum strengths arising from early clinical exposure with patients was "the acquisition of communication skills, professionalism, team-working skills and reflective practice".

In a discussion article, Foster Page (2016) argued that professionalism is a broad competency that is taught throughout dental schools and encompasses a range of attributes. The author suggested that professionalism in the dental curricula may be better addressed by social accountability, with dental schools working to develop dental professionals as socially accountable individuals.

Okala et al (2018), observed that an HIV stigma still exists across the medical and dental profession and that such patients still experience "discriminatory attitudes and behaviours" when attending a dental practice. Whilst not specifically examining or reviewing education, the authors, in their discussion stated that education was part of the solution and recommended that "culturally sensitive awareness and educational tools targeting the dental team should be developed to address the stigma around HIV in this clinical setting". They recommended that learning packages, accessible through online facilities should be developed for those in both undergraduate and continuing educational environments. This might raise awareness and improve professionals' approach to the management of patients with HIV.

#### Summary points

- Published papers include professionally defined formal curricula for professionalism developed for undergraduates and graduates. (COPDEND dental foundation curriculum 2015, Ranauta et al 2018)
- Studies have identified competencies for professionalism which include appropriate behaviours, knowledge to support safe patient care, self-awareness and ongoing development. (Zijlstra-Shaw et al 2012)
- While there is general agreement on topics, content and competencies for professionalism, there is also recognition of the complexity involved in teaching and assessing professionalism. (Neville et al 2018)
- Studies indicate that social and cultural competence are important, and teaching should address these concepts. (Foster Page et al 2016, Okala et al 2018)

#### 4.5.2.4. Assessment

A review by Zijlstra Shaw et al (2012) revealed that professionalism can be viewed as a separate competence or as part of other aspects of clinical competence. Aspects of professionalism, for example student traits, ethics, values, multiculturalism, empathy, trust and honesty have been assessed as well as interaction-based aspects of care including doctor–patient relationship, teamwork, patient satisfaction, confidentiality. The authors organise approaches to assessment into four main categories: written assessment, competency-based assessment, performance-based assessment, and portfolios, with some assessments being combined. They argued that a competency-based assessment may be a useful component of a systematic approach to assessing professionalism, especially in the earlier stages of the curriculum, but is unlikely to be useful as the single method for assessing the topic and that performance-based assessments, whilst time-consuming may provide further data with more authenticity. These performance-based assessments may include self-assessment, peer assessment, direct observations and other measures, which when combined may provide a clearer view of the student as a professional. These approaches to assessment were highlighted in the ‘Graduating European Dentist: A New Undergraduate Curriculum Framework’ document (Field et al 2017).

Bateman (2019), discussed the challenges of determining and assessing professionalism. The author argued that professionalism issues are influenced by context making professionalism a particularly challenging area for teaching and assessment. The author goes on to note recommendations from the literature which include: “a range of contributory content; account of context; the necessity of looking longitudinally and not just a 'moment in time'; and use of appropriate multi-source assessment and feedback mechanisms”.

Zijlstra-Shaw et al (2017), investigated the assessment of the professionalism of senior dental students during a period of training in an outreach facility. They utilised an Assessment of Dental Student's Professionalism System which was the first phase of a development process for assessing dental professionalism. They concluded that the assessment process was valid and reliable and promoted feedback and student reflection and that it could strengthen the process of assessment of dental students' professionalism.

**Summary points**

- Multiple methods of assessment including workplace-based assessments are recommended. (Zijlstra-Shaw et al 2012)
- The assessment of professionalism is deemed particularly challenging but longitudinal and contextual information are deemed to be useful. (Bateman et al 2019)
- Feedback and reflection are considered to strengthen learning and the value of assessment. (Zijlstra-Shaw et al 2017)

#### *4.5.3 Student behaviours outside the programme*

Using a questionnaire, Kenny & Johnson (2016) investigated dental students' use of social media, attitudes, behaviours and perceptions of professionalism. They reported evidence that the use of social media across the breadth of healthcare professionals is increasing. Students share information that is personal to them and use the media to express their views and opinions. These can relate to both personal and workplace issues and it is not always clear where the lines should be drawn. This lack of clarity can impact on the relationship between patients and their healthcare workers. Despite efforts to ensure that material stored online is securely protected, it appears that sites can be accessed and in addition many devices allow individuals to 'screen-shot' information they are viewing on their device adding risks not only from their own behaviour but also the behaviour of others.

Dobson et al (2019), investigated whether dental students had knowledge of the guidelines regarding social media, available on the GDC's website and if they perceived that they were behaving professionally with regard to their activities through online sites. Eighty-eight students from years 2 and 4 from the Bristol dental school programme, took part. The majority of students utilised social media extensively and were familiar with the GDC guidelines. The findings suggested that "the perception of students and their attitudes towards e-professionalism were both contradictory and complicated". All students, when referring to personal statuses and associated photographs, agreed the following should not be posted: the use of illegal substances; talking about their patients or teaching/support staff. However younger students, unlike their older counterparts, believed that it was unsatisfactory to post photos of themselves under the influence of alcohol. There was agreement across both year groups regarding photographs of themselves or their peers displaying sexually explicit pictures of themselves or taking illicit substances.

Nason et al (2018), assessed the level of professionalism of dental students' Facebook profiles. They found that Facebook is widely used by dental students. Student profiles contained significant personal details and references to them being students at a dental school. They detected information which would be deemed to constitute a lack of professionalism. The authors indicated that those who use Facebook are responsible for the privacy settings and information that can be made available to others.

**Summary points**

- Students routinely use social media, but it is not always clear where the lines should be drawn in terms of their personal and professional behaviours. (Kenny & Johnson 2016, Dobson et al 2019)
- Many students have learned about social media guidelines but applying this is more complex. (Dobson et al 2019)

- Many devices allow individuals to ‘screen-shot’ information they are viewing on their device adding additional risks from not only their own behaviour but also the behaviour of others. (Kenny & Johnson 2016)

#### 4.5.4 Teaching and Education: evidence from the wider literature

Birden et al (2014), undertook a narrative synthesis of 26 papers rated as high quality from a pool on the topic of definition of professionalism in medicine. They reported that a definition was needed to convey the meaning of the concept and support a shared professional identity. However, the conclusion from their analysis was that there is no universal agreement or overarching conceptual context of medical professionalism:

*the semantics of professionalism obfuscate more than they clarify, and the continually shifting nature of the medical profession and in the organizational and social milieu in which it operates creates a dynamic situation where no definition has yet taken hold as the definitive one.*

Dart (2019), reviewed seven studies and six national and international sets of competency standards to conceptualise and define professionalism for the purpose of teaching nutrition and dietetics. They identified four major themes from this literature: personal attributes; interpersonal communication; approach to practice; and commitment to lifelong learning. Personal qualities described included trustworthiness. Evidence-based practice was identified as an important subtheme and role modelling and mentoring were common elements defining professional practice. Other important themes included: an awareness of personal limitations and professional boundaries, safe and effective practice, and culturally competent practice.

In a systematic review of 46 articles, Mak-van der Vossen et al (2017) examined 205 different descriptions of unprofessional behaviours amongst medical students. A total of 30 categories were classified in four behavioural themes: failure to engage (including absence, lateness, disorganisation, poor teamwork and language difficulties), dishonest behaviour (including cheating, lying, plagiarism, not obeying rules and regulations), disrespectful behaviour (including poor communication, inappropriate use of social media, inappropriate clothing, bullying and discrimination), and poor self-awareness (including avoiding feedback, lacking insight, resisting change). Papadakis et al (2006), investigated linkage between lapses in professionalism and disciplinary action for medical graduates from three medical schools in the USA. They observed that those graduates who had been unprofessional at medical school were more likely to act unprofessionally in their future career and that behaviour as a professional during the undergraduate programme is a better “practice performance predictor” than academic performance at medical school.

A systematic review of 19 studies on remediation interventions for medical students and doctors (reported in 23 articles) undertaken by Brennan et al (2020), found that most remediation interventions were multifaceted and addressed professionalism issues alongside clinical skills. Some focused on specific areas (e.g. sexual boundaries and disruptive behaviours) and most used three or more behaviour change techniques. They found little evidence of outcomes or effectiveness due to the quality of the studies and lack of evidence. They concluded that research is required to improve the design and evaluation of interventions to remediate professionalism lapses.

In a systematic review of professionalism curricula in postgraduate medical education, Berger et al (2019) highlight best practices and identify gaps in knowledge. They concluded that “knowledge outcomes are the most likely to be significantly improved by educational interventions, followed by attitudes and then behaviour”. They found that curriculum duration was not associated with effectiveness and single sessions were as effective as longitudinal curricula and moral reasoning was not improved by more ethics lectures. They recommended small-group sessions focused on the psychosocial challenges of the profession as this was associated with lower burnout, depression, and anxiety. Multisource feedback appeared to have a positive influence on friendliness, respectfulness, and accountability and they recommended this as an “ideal method of evaluating professionalism, particularly the competencies related to demonstrating commitment to patients, as the individuals directly affected by a physician’s level of professionalism complete the evaluations”. In a systematic review of the use of multisource feedback for assessing surgical practice, Al Khalifa et al (2013) identified eight studies which met the inclusion criteria. They concluded that:

*[Multisource feedback] shows a promising, feasible, reliable, and valid means of assessing surgeons across a broad range of competences such as professionalism, leadership, interpersonal skills, collegiality, and communication skills*

Birden et al (2013), identified 43 articles as “best evidence” for how to teach professionalism. They determined that few studies provided comprehensive evaluation or assessment data which demonstrated success. They concluded that while it was agreed that professionalism should be taught, there was no unifying theoretical or practical model for professionalism teaching in medicine.

Guraya et al (2016), included 48 articles for detailed analysis in a systematic review. They identified that a diverse range of pedagogies were used for teaching medical professionalism. They reported that the most powerful and effective strategies included role modelling, mentoring, hidden curriculum, reflective practice, and effective communication. They described the importance of the role of staff as role models for demonstrating practicing with integrity, respect for patients, and altruism. They found that a range of approaches including interactive lecture, vignettes, small group teaching, simulation and videotape reviews had been identified as effective teaching tools. They also stated that there was no universally agreed model for integrating the teaching of professionalism in the medical curriculum.

In a systematic review of professionalism assessment, Li et al (2017) reviewed data relating to 74 instruments from 80 existing studies. They found that the quality of these studies was poor, overall. The authors stated that more work was needed to develop and test instruments but identified three instruments for assessing professionalism which were best rated and demonstrated the best performance: Hisar’s instrument for nursing students, ‘Nurse Practitioners’ Roles and Competencies Scale, and Perceived Faculty Competency Inventory’.

Another systematic review of the literature on professionalism assessment was reported by Wilkinson et al (2009). They reported five clusters of professionalism: adherence to ethical practice principles; effective interactions with patients and with people who are important to those patients; effective interactions with people working within the health system; reliability; and commitment to autonomous maintenance / improvement of competence in oneself, others, and systems. They identified nine main types of

assessment tools: observed clinical encounters, collated views of co-workers, records of incidents of unprofessionalism, critical incident reports, simulations, paper-based tests, patients' opinions, global views of supervisor, and self-administered rating scales. The authors concluded that professionalism can be assessed using a combination of approaches and further development is needed in terms of reflectiveness, advocacy, lifelong learning, dealing with uncertainty, balancing availability to others with care for oneself, and seeking and responding to results of an audit.

A systematic review of 14 studies of social media use in undergraduate, graduate and continuing medical education was reported by Batt-Rawden et al (2014). They highlighted that none of the studies looked at how social media could be used to negotiate healthcare systems or collaborate in the advancement of science. They concluded that social media could support improvements for clinical excellence, supporting the use of social media in education.

#### **Summary points**

- There is no consensus or standard in terms of the definition of professionalism for the purpose of teaching. (Birden et al 2014, Dart et al 2019)
- There is little evidence to show which are the best approaches for teaching professionalism, but studies have suggested a range of approaches including role modelling, mentoring, hidden curriculum, reflective practice, and effective communication. (Birden et al 2013, Guraya et al 2016)
- Studies have recommended that professionalism teaching includes and aligns theory and practice with interventions that include knowledge which then support learning for attitudes and behaviour. (Berger et al 2019)
- A wide range of tools have been identified and used for assessing professionalism. Many are deemed useful but there is limited evidence of effectiveness. (Wilkinson et al 2009, Li et al 2017)
- Social media provides both professional challenges and opportunities for educators. (Batt-Rawden et al 2014)

#### 4.6 Summary points from the REA

In this section we bring together all the summary points from the REA. In doing this, we re-ordered the question areas, added some sub-divisions (for example, social media) and included a group on barriers and enablers to professionalism.

##### *Public expectations*

- A sense of trustworthiness and being treated with dignity and respect were found to be important. (Zijlstra-Shaw et al 2013, Chandarana & Hill 2014, Muirhead et al 2014)
- Approaches such as being polite, respectful and helpful are markers of professional behaviour, along with compassion, integrity and trustworthiness. (Zijlstra-Shaw et al 2012, Taylor & Grey 2015)
- Patients, including young people, desire to be given information to facilitate their involvement with decision-making about their treatment and care. Within the appointment, it was reported that time is needed to explain treatments to children. (Morgan et al 2017)
- Informed decision-making and consent are widely discussed in opinion pieces and commentaries. Involving the patients in decision-making is recognised as involving



- two-way communication. (O'Keefe 2015, Burke et al 2017a, 2017b)
- Dress and appearance influence patients' perspectives of the clinician's professionalism and how at ease and receptive to treatment they feel. Traditional dental attire is valued by patients, although children may prefer more casual attire. (Mistry & Tahmassebi 2009, Furnham et al 2013)
  - The literature suggests that good use of skill mix and teamwork are an important aspect of dentistry. Trust, communication and understanding the roles influence patient perspectives on the delegation of care to dental therapists. (Dyer et al 2010, Dyer et al 2013)
  - But in contrast to other aspects of care (such as putting the patients' interests first) teamwork was deemed less important. (Chandarana & Hill 2014)
  - Patients' care seeking behaviour and perceptions of care can be influenced by costs and value for money. Studies exploring patient perspectives on dental care were consumer experience focussed. (Tickle et al 2015, Cope et al 2018)

### *Social media*

- Notable numbers of patients look for online information (qualifications, reviews) about their dentist. (Parmar et al 2018)
- Opinion is divided on what is unprofessional use of social media outside the workplace and how this should reflect on in-work professionalism. Some argue that judgement of professionalism should focus on patient care (Affleck & Macnish 2016). Whereas, others suggest that where public exposure of such behaviour comprises the professional role, it is unacceptable even outside the workplace. (Holden 2017)
- Studies have identified concerns about information on social media resulting in the public assuming "guilt by association". (Dobson et al 2019)
- Fewer dentists than patients think social media friendship is appropriate. (Parmar et al 2018)
- Few GDC fitness to practise cases relate to social media although this does not account for unreported cases or university fitness to practise processes. (Neville 2017)

### *Why are these areas of professionalism perceived as important?*

- Being empathetic with anxious patients can enhance outcomes. (Ahmed et al 2016)
- Involving patients in the decision-making process enhances relationships between patient-dentist. (Nowack et al 2018)
- In recognising the importance of being treated with dignity and respect, and given clear information, patients were more likely to judge that treatment was appropriate and of a high standard. (Mills et al 2015)
- The importance of good communication is evidenced in studies of children where poor communication can negatively affect anxiety and where staff behaviour is found to vary depending on whether the procedure (application of fluoride varnish) was successful or not. (Zhou et al 2012, Morgan et al 2017)
- Patient and public views of time management specifically highlighted the availability of dental appointments which affected whether or not they were able to obtain appropriate dental care in a timely manner. (Tickle et al 2015, Cope et al 2018, Okala et al 2018)

### *Barriers and enablers of professionalism*

- Teamwork is recognised as important, and in addition to good communication, effective teamwork is influenced by a range of factors operating at the micro, meso and macro levels. (Bullock & Firmstone 2011, Morison et al 2011, Ajjawi et al 2017)
- Dentists are encouraged to make decisions in the best interests of patient but there are many challenges in this process which include financial disincentives, patient expectations and challenging working environments. (Affleck et al 2013, Alani et al 2015, Al Hassan 2017, Holden 2017)
- Tools (such as checklists, reporting systems, trigger tools, alerts on electronic notes) are available that may help ensure a safe environment for care delivery, but the safety culture of the organisation and leadership are important. (Bailey et al 2016)
- Problematic teamwork is associated with poor professional behaviours; this is evidenced in the literature through reported incidence of bullying. (Steadman et al 2009, Neville 2017)
- The dental professionals' ability to communicate with patients can be affected by the demands of general practice, their patients' requirements, limited by time-constraints. (Holden 2011, Nowak et al 2018)
- Patient choice is considered to be important for care, but advertising and the media can influence patient expectations and generate unrealistic demands and contribute to young dentists feeling stressed. (Alani et al 2015, Al Hassan 2017, Holden 2017, Sellars & Wassif 2019).
- Although working in the best interests of the patient is a central pillar of professionalism, conflicts of interest may arise from patient demands and financial incentives and cases of fraud and dishonesty are common in cases of professional misconduct. (Singh et al 2009, Trathen & Gallagher 2009, Ahmad 2010, Alani et al 2015, Affleck et al 2017, Parmar et al 2018).
- Discussion papers draw attention to ethical conflict between care and financial pressures on a practitioner and at the organisational level. (Alani et al 2015, Bagg & Welbury 2015, Bissell & Felix 2015, Affleck et al 2017)
- Studies of dental professionals suggest that clothing is a symbol of professional identity but that traditional uniforms may reinforce a sense of hierarchy in the dental team. (Morison et al 2011)

### *Categorisations of professionalism*

- There were mixed opinions on what professionalism looked like in the dental care setting (favourable around communication-related issues; less favourable with perceived lack of access to care and high costs) which appeared to be influenced by a range of factors (including dental anxiety, socio-economic status, poor prior experience and cost).
- Categorisations of professionalism were often explicit in the literature. Implicit from the summary points above, key areas of professionalism relate to expected service experience, patient experience of interactions with dental professionals, professionalism in dentistry and the personal and professional divide.

### *Is dentistry different?*

- Themes in the dental literature on patient perspectives of professionalism particularly in relation to interpersonal experiences, traits of professionals and communication skills echo those seen in the wider healthcare literature. (Bastemeije et al 2017, Chan et al 2012)
- Patient autonomy and experience appear throughout the literature.

- There appears to be less focus on the financial conflicts of care in the wider healthcare literature.
- Issues of clinician burnout and the effects on patient experience and care feature in the healthcare literature but have received less attention in the dental literature.
- Studies indicate that bullying and harassment are an issue in healthcare, with significant effects on wellbeing but there is little evidence to show how to address this. (Halim & Riding 2018)

### *Teaching professionalism*

- Studies have identified competencies for professionalism which include appropriate behaviours, knowledge to support safe patient care, self-awareness and ongoing development. (Zijlstra-Shaw et al 2012)
- Published papers include professionally defined formal curricula for professionalism developed for undergraduates and graduates. (COPDEND curriculum 2015, Ranauta et al 2018)
- Provision of a safe environment for care delivery requires that processes and procedures are in place and followed. (Taylor & Grey 2015)
- Ensuring safety also needs knowledge of the limits of competence and raising concerns as appropriate. (Gilmour et al 2014)
- Papers reporting professional perspectives related to the clinical environment focus on skills and training rather than patient experience. There is some evidence to suggest that more education and training is needed in non-clinical skills, such as communication and professionalism. (Gilmour et al 2014, Oliver et al 2016)
- While there is general agreement on topics, content and competencies for professionalism, there is also recognition of the complexity involved. (Neville et al 2018)
- There is no consensus or standard in terms of the definition of professionalism for the purpose of teaching. (Birden et al 2014, Dart et al 2019)
- No one approach is considered to be the most effective or successful for teaching professionalism. (Field et al 2010)
- There is little evidence to show which are the best approaches for teaching professionalism, but studies have suggested a range of approaches including role modelling, mentoring, hidden curriculum, reflective practice, and effective communication. (Birden et al 2013, Guraya et al 2016)
- Studies have recommended that professionalism teaching includes and aligns theory and practice with interventions that include knowledge which then support learning for attitudes and behaviour. (Berger et al 2019)
- Professionalism teaching and learning curricula are considered to be important. Learning is achieved through the formal and hidden curricula and these need to be well aligned for learning. (McHarg & Kay 2009, Beattie et al 2012)
- Studies show that teaching that uses learning from emotionally challenging events, incidents and narratives of dilemmas can support student learning. (Monrouxe et al 2015, Taylor & Grey 2015, Ranauta et al 2018)
- Studies have identified positive role models and professional identities as having a significant influence on professional development. (Morison et al 2011, Vivekananda-Schmidt et al 2015)
- Studies indicate that social and cultural competence are important, and teaching should address these concepts. (Foster Page et al 2016, Okala et al 2018)

- Positive professional characteristics and attitudes of students are regarded as being important for dentistry but the extent to which these characteristics are innate or are learned and developed is unclear. (Kay et al 2010, Faulks et al 2018)
- There are arguments for using admissions procedures and interviews designed to select students for dentistry who demonstrate “desirable” attributes. (Kay et al 2010)
- There appears to be a greater sense of needing to learn about professionalism topics at a postgraduate level, with undergraduates, reporting that clinical skills are more important. (Chandarana & Hill 2014, Oliver et al 2016)

### *Social media*

- Social media provides both professional challenges and opportunities for educators. (Batt-Rawden et al 2014)
- Many students have learned about social media guidelines but applying this is more complex. (Dobson et al 2019)
- Dental students identify posting of images on social media of students intoxicated or drinking alcohol or discussing interactions with patients as unprofessional behaviours. (Kenny & Johnson 2016)
- Dental professionals may need more support around social media use for learning for promoting their practices and learning. (Neville & Waylen 2015)
- Many devices allow individuals to ‘screen-shot’ information they are viewing on their device adding additional risks from not only their own behaviour but also the behaviour of others. (Kenny & Johnson, 2016)
- Areas of concern and risk include patient confidentiality and maintaining a professional image.
- Social media is widely used by students and this is recognised as a risk to students’ professional standing. (Kenny & Johnson 2016, Nason et al 2018, Dobson et al 2019)
- Students routinely use social media, but it is not always clear where the lines should be drawn in terms of their personal and professional behaviours. (Kenny & Johnson 2016, Dobson et al 2019)
- There is general consensus that guidelines are needed for healthcare professionals in relation to social media.

### *Evidencing professionalism*

- The assessment of professionalism is deemed particularly challenging but longitudinal and contextual information are deemed to be useful. (Batemen et al 2019)
- A wide range of tools have been identified and used for assessing professionalism, many are deemed useful but there is limited evidence of effectiveness. (McHarg & Kay 2009, Li et al 2017)
- Multiple methods of assessment including workplace-based assessments are recommended. (Zijlstra-Shaw et al 2012)
- Feedback and reflection are considered to strengthen learning and value of assessment. (Zijlstra-Shaw et al 2017)

## 4.7 Summary of how the evidence addresses the four research questions

*Research Question 1: What aspects of professionalism does the public expect from dental professionals (and why are these perceived as important)?*

Members of the public expect a consumer service from the dental team. The financial and transactional elements of dental care influence patient experience, access to care and trust. Patients expect technically good care, and, on balance, this appears to be more important to them than other aspects of professional behaviours. Dental professionals are expected to be trained to provide dentistry and to be up to date in their clinical practice.

Patients expect to have their interests put first and to be involved in decision-making about their treatment and care. They expect to be treated with dignity, respect and compassion.

These expectations are important to patients because a caring manner and good communication can lessen patient anxiety and enhance the patient's assessment of the quality of the care. Involvement in decision-making helps to develop trust.

Dental professionals focus more than patients on the technical aspects of what can and should be delivered, and aspects of teamwork.

We noted barriers to professionalism in operation at micro, meso and macro levels in a complex mix. Working in the best interests of patients may be challenging because of financial disincentives and pressures, unrealistic patient expectations and working environments. The quality of communication can be limited by time-constraints and patient requirements. Workplace issues identified by dental professionals include bullying and poor professional behaviours towards members of the team, but these were not issues highlighted in studies of patients.

*Research Question 2: How can aspects of professionalism be categorised?*

Categorisations of professionalism were not often explicit in the literature. From our analysis of the literature, we identify three key areas of professionalism.

Expected service experience which would include:

- Safe and clean practice.
- Timeliness of services (getting appointments and being seen on time).

Interpersonal patient experiences which focuses on the patient experience of interactions with dental professionals:

- Communication skills, including listening, empathy, trustworthiness, conveying a sense of being treated with dignity and respect.
- Being empowered and involved as a partner in making decisions about their own care.
- Feeling that decisions are financially fair and are based on their own needs and not financial pressures on the dentist.
- Being able to understand proposed treatment and the costs of dental care.

Professionalism in dentistry and the personal and professional divide

- Expectations of a dental professional and their behaviour in their personal life (being someone who can be trusted to make an appropriate decision).

*Research Question 3: Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals?*

The literature suggests that many aspects of professionalism are similar to other healthcare professions. The most marked differences appear to lie in the transactional, financial and contractual areas of practice. The costs associated with dentistry influence how professionalism is viewed, which may explain why patients express their views of dentistry in similar terms to those of other transactional consumer services. The financial and wider pressures on decisions were identified as a concern for patients and a source of stress and challenge for dentists. We also note that the wider healthcare literature gives more attention to reporting research on clinician burnout compared to the dentistry literature.

*Research Question 4: The teaching of professionalism – how does the undergraduate curriculum prepare students to meet professionalism expectations and how is this evidenced?*

Although formal curricula for professionalism have been defined, teaching and assessing professionalism is recognised as complex. Alongside the formal curriculum, mentoring and reflective practice, role modelling and the hidden curriculum play a notable part in the development of professionalism. No one approach is the most effective or successful for teaching professionalism and multiple approaches are encouraged.

Students appear to feel that professionalism topics are well covered in the undergraduate curriculum. Applying social media guidelines and determining personal from professional behaviour was a specific area identified for additional support. Qualified dentists identified gaps in their teaching, possibly as undergraduates are often protected from many real-world issues. In addition, students prioritise clinical competence and do not engage as much with ‘non-clinical’ topics.

Assessing professionalism is challenging and the use of multiple methods and tools is encouraged for evidencing professional development, including workplace-based assessments and measures that are longitudinal and provide a better view of professionalism. Feedback and reflection can strengthen the value of assessment.

#### *4.6.2 Gaps in the literature*

- There is limited evidence to indicate what patients see as the core of dentistry as a service and as a profession..
- The evidence relating to professional lapses focuses predominantly on individuals and is limited in terms of addressing the respective roles of the dental team, and organisational and system (such as the NHS) influences on care.
- There are considerable anxieties amongst the dental profession particularly in relation to payments and systemic pressures on practice but there is little information to indicate how these should be overcome particularly as the evidence often centres on the individual and not on the system.
- There is little evidence relating to the penalties associated with lapses in professionalism or criminal conviction and what would be appropriate within specific

contexts. Similarly, there is little evidence considering approaches to addressing lapses in professionalism, for example the role remediation.

- The interface between the law and dentistry and approaches for managing these pressures on professional practice (often defensive dentistry) have not been considered in any detail.
- There is little evidence explaining concepts of seriousness in terms of lapses of professional behaviours and how these are mitigated or addressed.
- There are many areas where there is no clarity in terms of *how* professional or unprofessional a behaviour is.
- Positive concepts of professionalism in teaching are rarely explored in the undergraduate curriculum, and there is a lack of research to address the conflict between the teaching of positive and supportive approaches to professionalism and the influence of concerns about fitness to practise in shaping student and trainee attitudes and understanding
- Technology and social media are emerging issues but the evidence relating to how these can and should be addressed is limited.

## PART 5 – KEY FINDINGS FROM THE FOCUS GROUPS

### 5.1 The Data and Analysis

The team conducted eight focus groups, discussing the topic of professionalism in dentistry with a variety of participants. Three of the groups were recruited from members of the public, who talked about their experiences of going to the dentist. There were four groups where all participants were qualified dentists and one focus group where all participants were DCPs. Two other DCPs (referred to by pseudonyms below) who were unable to attend the DCP focus group were interviewed individually by telephone. These one-on-one interviews were analysed together with the focus groups. Table 6 provides an overview of the focus group participants.

*Table 6: Focus group participants*

	Participants	Men	Women
Dentist 1	5	4	1
Dentist 2	2	0	2
Dentist 3	9	4	5
Dentist 4	3	1	2
<i>Sub tot</i>	<i>19</i>	<i>9</i>	<i>10</i>
DCP Group	13	2	11
DCP Olivia	1	0	1
DCP Tina	1	0	1
<i>Sub tot</i>	<i>13</i>	<i>2</i>	<i>11</i>
Public 1	7	2	5
Public 2	6	3	3
Public 3	6	3	3
<i>Sub tot</i>	<i>19</i>	<i>8</i>	<i>11</i>
<b>Total</b>	<b>51</b>	<b>19</b>	<b>32</b>

Recordings were made of all focus group discussions. These were transcribed verbatim and transferred to NVivo for thematic analysis. Throughout the report we indicate differences of opinion between the groups where appropriate by distinguishing between dentists, DCPs (including the two telephone interviews), and the public. When referring to the dentist and DCP groups together, we use the term *dental groups*.

In this report we list all the codes that were used during the focus group analysis, provided they appear at least 10 times across the focus groups. The codes are grouped into five themes which correspond to the themes identified in the analysis of the scoping interviews. There were some codes which appear in the focus groups but not the scoping interviews and we have also added sub-codes to existing codes to capture the discussions in more detail.

Each thematic section ends with a short summary of main points.

### 5.2 Overview of Findings

Table 7 lists the codes grouped into the five themes. The columns show how many times each code appeared in the DCP, dentist, and public focus groups.



Table 7: Focus group data analysis: an overview of themes and codes

THEME\CODE	Dentist total	Number of times	
		DCP total	Public total
principles\motivation\financial	37	16	39
principles\motivation\altruism–patients’ best interests	18	4	0
principles\regulations	15	0	0
principles\ethics and values	6	7	2
principles\mental health	10	0	0
attitudes and behaviours\interacting with patients	59	32	76
attitudes and behaviours\working in a team	17	26	16
lapses\outside of workplace	45	5	18
lapses\complaints	45	14	10
lapses\social media	27	7	16
lapses\attire	21	12	15
lapses\switching dentist	6	0	18
lapses\hygiene	2	3	16
lapses\time keeping	11	1	1
contexts\healthcare	16	6	18
contexts\children	9	1	24
contexts\other professions	13	5	14
contexts\generations	15	6	5
contexts\cosmetic	3	2	8
contexts\surgery space	0	0	14
contexts\culture	11	1	0
learning and development\safety	23	7	11
learning and development\clinical competence	15	9	0
learning and development\challenges	17	4	0
learning and development\insight and reflection	8	7	0
learning and development\learning by observing	9	1	0

### 5.3 Theme 1 – Principles

The codes for the principles theme are displayed in table 8.

*Table 8: Codes within the principles theme, by group*

Code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Financial motivation (94)	0	3	13	11	5	17	4	14	12	13
Altruism (20)	1	1	2	7	3	5	3	0	0	0
Regulations (15)	0	0	0	3	3	0	9	0	0	0
Ethics & values (14)	0	2	5	1	3	2	0	0	2	0
Mental health (10)	0	0	0	1	2	6	1	0	0	0

#### 5.3.1 Financial motivation

Financial concerns were identified as one of the important factors shaping professionalism in most of the focus groups. This code was divided into the four sub-codes listed in Table 9. The public participants were primarily concerned with being able to afford treatment, and whether dentists are prioritising profit over the best interests of the patient. Some dental participants expressed frustration about how they are viewed by the public, perhaps because of a small minority of profit-focused individuals. They also noted that financial pressures could be a barrier to professionalism.

*Table 9: Financial motivation sub codes, by group*

Sub code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Profit (39)	0	0	6	3	4	10	2	2	3	9
Affordable (22)	0	0	0	3	1	1	0	5	6	6
Pressure (14)	0	0	5	4	0	2	0	1	2	0
Expectations (10)	0	3	0	2	0	2	0	0	3	0

##### 5.3.1.1 Profit

These discussions suggest that (some) dentists are motivated by making a profit, sometimes even going against the best interest of the patient. This idea appeared in all focus groups, but not the two telephone interviews. In the DCP group participants shared anecdotes about colleagues using sub-standard materials to increase profit margins. Dentists stated that they ‘have to run a small business’ and discussed cases of financial fraud and trainees who are motivated by making a profit. Public groups did say that in contrast to doctors, dentists want to make a profit although no specific evidence was provided for this idea. Furthermore, they also complained that NHS patients are treated badly, and in some cases they felt humiliated in front of private patients.

*General[dental] practice is fundamentally a business, isn't it? So, it's always going to be driven by money unfortunately. (DCP group)*

*It's a business. The more people he sees, the more money he makes and I think that makes it harder because it's not easy to have what ends up being a 10 minute check-up to be a 15 minute check-up just because he's having a bit of a conversation. That extra five minutes is half the time of someone else, and I think that's what makes it different. (Public group 3)*

#### 5.3.1.2 Affordable care

All public groups raised the issue of being able to afford dental treatment – whether privately or through the NHS. Several participants argued that dental care should be free for those in financial need. Other participants claimed that it is worth going private for a better quality of service. Three of the dentist groups also mentioned their patients' ability and willingness to pay for treatment.

*Yeah. I mean, I'm from [PLACE] and for some unknown reason people think we're posh. We ain't and they think there's load of money down there. If there is I ain't got it, and we have some dentists that won't take on NHS. (Public group 3)*

#### 5.3.1.3 Pressure

The dental focus groups put forward the idea that financial pressures restrict professionalism because the existing NHS contract limits the amount of time that can be spent on procedures. The public groups noted that the NHS is under a lot of pressure, which has an impact on the service that can be provided.

*The NHS is under so much pressure anyway. You see it on the news all the time. They're under so much pressure nowadays. Going private for now, I think is technically I think better. It puts less stress on the NHS I think, but it shouldn't be like that. (Public group 2)*

#### 5.3.1.4 Expectations

Similarly to points raised in the scoping interviews, the focus groups (dental and public) suggested that patient expectations are influenced by the need to pay, in contrast to seeing a GP.

*I think that's one of the big differences between medicine, that money changes hands in dentistry. We're probably closer to vets really than doctors. (Dentist group 1)*

#### 5.3.2 Altruism

All dental focus groups referred to the idea of working in the patient's best interest.

*I think we've gone into it because we all care. Every one of us whenever we say about the patients, we've all got that caring element. We have not gone into this for money or things. It's that caring side. (DCP group)*

The public focus groups did not discuss this concept.

#### 5.3.3 Regulations

Three of the dentist groups made explicit references to existing or proposed regulations to guide professionalism. There was a mixed approach to regulations: some claimed that they can get in the way of 'actual important things'; there were also complaints that there is too much regulation although increased standards related to cross-infection control were seen as a positive change; others were keen to see more 'guidance' around behaviours outside the surgery, which caused one group to question who would be well placed to provide guidance.

*I think sometimes the prescriptive nature of things almost is counterproductive. ... We've got all these lists of things that we're supposed to do. How many fire lectures have you been to? And sometimes those things take the time for the actual important things of learning to do your real job better. (Dentist group 1)*

### 5.3.4 Ethics and values

Ethics and values were discussed as an aspect of professionalism in six of the focus groups. These were mostly dental focus groups, with one public focus group that discussed ethics in relation to two specific examples shared by the participants.

*I think sometimes professionalism is not always what you do in front of people. It is what you do when no one is looking.... It's when there's no one about, are you cutting corners, or that type of thing. (DCP group)*

### 5.3.5 Mental health

Mental health issues were only raised in the dentist focus groups. Participants identified isolation and substance abuse as the biggest issues affecting dentists.

*We have an issue with students committing suicide as well. So, the whole thing is are we looking after the mental health of the professional people turned to alcohol and substance abuse? (Dentist group 3)*

#### Summary points - principles

Dental groups discussed a greater variety of underlying principles than the patient groups. They talked about the impact of regulations, financial pressures, and isolation on the profession. They implied that they work in the patients' best interests but are nevertheless seen by some as focused on the business aspect of practice because of a small minority of dentists who prioritise profit. The public was indeed concerned with dentists working for profit, although they did not report any evidence which directly supported this idea. Ethics were mentioned in the public groups in relation to specific examples of questionable behaviour.

## 5.4 Theme 2 – Attitudes and behaviours

There were only two codes in this theme, as displayed in Table 10: *interacting with patients* and *working in a team*. Both topics were discussed extensively across the focus groups. The dental and public groups had similar opinions about appropriate attitudes and behaviours, although there were differences in focus between the two groups.

Table 10: Codes within the attitudes and behaviours theme, by group

Code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Interacting with patients (159)	9	10	13	17	7	25	10	28	20	28
Working in a team (59)	1	4	21	1	6	5	5	4	5	7

### 5.4.1 Interacting with patients

The most discussed topic across all groups was communication between the dental team and patients. This expansive topic was divided into the sub-codes listed in Table 11.

Table 11: Interacting with patients sub codes, by group

Sub code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Importance of communication (33)	5	3	7	0	3	3	4	3	4	1
Good communication (54)	3	3	2	5	0	3	0	15	9	12
Poor communication (47)	2	3	3	2	0	6	4	6	10	12
Challenges in communication (24)	0	0	3	10	2	5	4	0	0	0
Building rapport (21)	2	3	1	3	2	6	0	0	4	0
Patient Fear (18)	0	0	0	0	0	0	0	2	10	16
Developing communication (16)	0	0	2	0	4	6	0	1	3	0

#### 5.4.1.1 Importance of communication

Several participants stated that good communication was the most important aspect of being professional. The dental groups suggested that good communication can help to avoid official complaints, making these ‘soft skills’ even more important than clinical knowledge.

*For us one of the first things that we were taught was effective communication with patients and I think for me to this day it sits at the top tier. (DCP Olivia)*

*Normally it's actually on communication, that comes down to the complaint really. The way that I handled something in my communication. (Dentist Group 2)*

*I think the most important thing for me would be that a dentist is personable with their patient and has patience with them. Because there's nothing worse than feeling rushed and they just want to get you out of the room as quick as possible. (Public group 2)*

#### 5.4.1.2 Good communication

In the focus groups participants shared a variety of examples of what they saw as ‘good’ communication. Empathy, compassion, politeness, and friendliness were identified as key attributes for making patients feel like they are treated as a person. Making conversation was seen as instrumental in putting the patient at ease. It was also highlighted that patients want clear explanations of treatment options without being overwhelmed, and especially the younger generations want to be involved in the decision-making process rather than being told what to do or what is going to happen. The different groups highlighted the similar issues.

*Being well-mannered, you know, you're courteous, polite and caring towards your patients, I think that's professional. (Dentist Group 1)*

*I've got a very good dentist because he's friendly and approachable and you can talk to him and the staff are the same... They look friendly and they smile, and they talk to you and they listen to you. All the sort of things that any patient wants. (Public group 1)*

#### 5.4.1.3 Poor communication

Poor communication was described as unclear, robotic, rude, condescending, rushed, overly familiar, non-existent, or not respecting privacy (discussing patient issues within earshot of other patients). Poor communication might also extend to body language, for example sitting with legs up on a chair, which was seen as giving a bad impression to patients.

*We've had a member of staff receive two complaints in one day. Not because of their competency, but because of their conduct with the patients. (DCP group)*

*Sometimes [newly qualified dentists] don't speak at all. And you're going, well, how is rapport being built? They don't speak at all (Dentist group 3)*

*If they talk about something else or if they're talking about your teeth, when they're checking them, and they're not really sure, and they're humming and hawing, you're going to be lying there thinking can I actually trust this person? (Public group 2)*

#### 5.4.1.4 Challenges in communication

The dental focus groups also shared potential communication challenges, for example asking patients to put their phones away, dealing with patient anxiety, giving the right

amount of information to patients, dealing with confrontational patients, maintaining a professional manner for extended periods of time, and bumping into patients outside of work.

*We say 'no phones', and I don't feel we can challenge patients... if we've got our phones on us, so it has [to] work both ways, but ...basically we have the right to challenge them to make sure their phones are away. (DCP group)*

*... the way that you say things. I try not to be abrupt and I'm not trying to dictate terms to them. But at the same time, I have to give them bad news, they don't want to hear me say it, but I have to. (Dentist group 2)*

#### 5.4.1.5 Building rapport

The focus groups discussed the importance of dentists building rapport and trust with patients, and how expectations can change over time with returning patients. The public and professionals shared the view that dentists should be more formal with patients at first, shifting to a more informal approach over time. There was also agreement that seeing the same dentist for an extended period of time can help improve the experience of going to the dentist.

*I think there's a bigger expectation from patients to dentists, I think, and dentistry. Because you see these people regularly, every sort of couple of months, three months, four months, six months, and you build a bigger rapport I think with your dentist or your therapist or your hygienist. (DCP Tina)*

*I've been to the same dentist now for absolutely years. And he got to know me, and always asks what am I doing now and that was really important to me... building a rapport and making me trust him more. (Public group 1)*

#### 5.4.1.6 Patient Fear

Evidence suggested that experiences of professionalism in dentistry impacted on patients in important ways. There were participants in every public group who admitted being afraid of the dentist. This was described as due to a bad experience at the dentist as a child, fear of pain, fear of needles, or a combination of these.

#### 5.4.1.7 Developing communication skills

There were also discussions about whether and how communication skills can be learned. Some dental professionals were of the opinion that communication skills are innate and cannot be taught. This was refuted by other participants who talked about communication training in the university curriculum and learning on the job. The public questioned whether dental professionals received any formal communication training and expressed the view that they should do so.

*The young dental foundation dentists now can't communicate. You know, academically they're very intelligent but they can't use their hands and they can't communicate. (DCP group)*

*I was never really taught how to give bad news and that sort of thing.... But I think that's innate, I think ... at dental school, at interview, we were probably chosen because we could communicate... in the old days. (Dentist group 2)*

#### 5.4.2 Working in a team

This code was used to capture discussions about the dental team. Most of the references focussed on the differences between roles within the dental team. In the dental focus groups, there were also discussions about working together as a team and joint responsibility in delivering good care. There was an understanding that the various

roles entail different expectations and responsibilities, but there was disagreement on what exactly those differences should be. For example, some participants argued that dental nurses should be held to lower standards of professionalism because over-regulation might encourage them to look for other avenues of employment. Others argued that standards should be applied equally across the team. While the dental groups discussed the roles of the dentist, nurse, hygienist, therapist, and technician, patients also drew attention to the importance of the role of the receptionist as the first point of contact.

*...the team understanding all the roles, all the responsibilities, and having that shared understanding of who does what and how and it's simply not there. It's simply not there. (DCP group)*

*I don't think that I could give the care I give unless I had a dental nurse who was actually preparing all the equipment.... To me it's a team... and I would expect my dental nurse to tell me if something wasn't right. And they would, they'd say 'look that wasn't quite right' or such and such.... I think if you have you had two standards then you may end up with a hierarchical system. (Dentist group 2)*

#### **Summary points – attitudes and behaviours**

There were only two codes in this theme: *interacting with patients* and *working in a team*. Both topics were discussed extensively across the focus groups. The dental and public groups had similar opinions about appropriate attitudes and behaviours, although there were differences in focus between the two groups.

Communication was widely discussed in all groups. Good communication was considered a very important aspect of professionalism. Empathy, compassion, politeness and friendliness helped patients to feel treated as a person and making conversation was seen as instrumental in putting patients at ease. It was also highlighted that patients want clear explanations of treatment options without being overwhelmed. Poor communication was described as unclear, robotic, rude, condescending, rushed, overly familiar, non-existent, or not respecting privacy. The dental focus groups also shared potential communication challenges, for example, managing the anxious patient or a confrontational patient.

The importance of dentists building rapport and trust with patients was discussed. The public and professionals shared the view that dentists should be more formal with patients at first, but may become more informal over time.

There were also discussions about whether and how communication skills can be learned. Some dental professionals thought that communication skills are innate, but others discussed the value of education and training. The public were not knowledgeable about whether dental professionals received formal communication training but thought they should do.

In the dental focus groups, there were also discussions about working together as a team and joint responsibility in delivering good care. There was some disagreement on whether DCPs should meet the same standards of professionalism as dentists. Some argued that lower standards of professionalism should apply to dental nurses; others that standards should be applied equally across the team. While the dental groups discussed the roles of DCPs, patients focused on the role of receptionist as their first point of contact.



## 5.5 Theme 3 – Lapses

Professionalism lapses formed a major part of discussions (see Table 12). We identified seven main codes and the most prevalent of these comprised four sub codes.

*Table 12: Codes within the lapses theme, by group*

Code (tot)	DCP Olivia	DC P Tina	DCP group	Dentist t 1	Dentist t 2	Dentist t 3	Dentist t 4	Public c 1	Public c 2	Public c 3
Outside of workplace (68)	0	2	3	8	9	13	15	7	7	4
Complaints (66)	2	1	11	8	2	26	9	7	2	1
Social media (50)	0	2	5	10	9	4	4	10	2	4
Attire (48)	4	5	3	7	7	2	5	2	10	3
Switching dentist (24)	0	0	0	2	0	3	1	15	2	1
Hygiene (21)	1	0	2	0	2	0	0	5	7	4
Time keeping (13)	0	1	0	10	0	0	1	1	0	0

### 5.5.1 Outside of workplace

Professional behaviour outside of the workplace was discussed in greater depth by the dental groups than the public groups. We identified four sub codes (Table 13).

*Table 13: Outside of workplace sub codes, by group*

Sub code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Alcohol (31)	0	2	3	2	8	3	2	1	6	5
Interactions (19)	0	1	1	4	0	5	5	1	2	0
Legality (18)	0	0	0	1	1	3	5	1	5	2
Judgment (11)	0	0	0	1	1	4	4	0	0	0

#### 5.5.1.1 Alcohol

Drinking alcohol was discussed in every focus group where behaviour outside of the workplace was mentioned. In general, drinking seemed to be viewed as less acceptable for dentists than other professional groups, for example lawyers. There were suggestions that going to a different town, drinking at home, only drinking on weekends, and not posting photographs of parties on social media can mitigate the impact on a dentist's reputation. No one suggested that alcohol should be completely avoided, but there were different views about the appropriate circumstances for drinking. In contrast, drugs were framed as something unquestionably unprofessional due to their illegal status, although it was recognised that some dental professionals do take illegal recreational drugs. The public was much more lenient in this matter than the dental groups.

*Going to work with hang-over and feeling rough I would see it as unprofessional. Getting drunk on a Friday night and I'm not working the next day I don't think I'd consider that unprofessional. (Dentist group 1)*

*It would only concern me if they were either blindingly drunk or doing something that they shouldn't be. Or what I think they shouldn't be doing, but otherwise it wouldn't bother me. (Public group 2)*



#### 5.5.1.2 Interactions

There were also discussions about interacting with members of the public outside of the surgery. This covers a range of interactions from being recognised on the street to developing friendships or romantic relationships with patients and getting into 'road rage' incidents with strangers. Most of these comments suggested that dentists need to be careful about their behaviour, even outside of the workplace, although some participants stated that such incidents have no impact on professionalism.

*It extends outside of the work environment... You could be at a football match, ok and people might be chanting and stuff. And you think, I can't take part in this chant, I'm a dentist. (Dentist group 4)*

#### 5.5.1.3 Legality

In addition to recreational drugs, participants discussed tax fraud, speeding, domestic violence, and criminal activities in general. Some viewed illegal activities as unquestionably unprofessional, while others argued that certain activities did not cause any harm and therefore should not concern the GDC.

*I talked about drug taking just now, that is in my mind 100% a 'no-no' but you'll get students and professionals taking those drugs... But 1. it's an illegal activity and 2. it's not professional. (Dentist group 4)*

#### 5.5.1.4 Judgment

This sub-code was used for instances where a participant claimed that the public judge dentists for unspecified behaviours or behaviours that did not fit into the above sub-codes.

*You can enjoy yourself. I'm sure you can. But if a patient sees you doing something that for someone else can be quite normal, will they be happy to come in for that filling on Monday or will they... how will they judge you on what you're doing. (Dentist group 1)*

#### 5.5.2 Complaints

Complaints were mentioned at least once in every focus group. However, there were extended discussions around this topic in the dental groups, especially in one dentist focus group where a participant who was at the time being investigated, repeatedly brought up the topic. The approach to complaints was very different in the two groups. Dental groups talked about 'defensive dentistry' and a 'climate of fear', describing a situation where dental professionals are terrified of being sued. In two of the dentist groups, participants criticised the GDC for being too quick to follow-up complaints, too strict in the complaints process, or having a 'guilty until proven innocent' mentality. Some dentists also shared narratives illustrating the severe impact of being investigated, even in the case of a positive outcome.

*I've actually got a dentist working for us who doesn't want to treat hardly anything, because she's afraid of getting sued... and when spoken to she's petrified of being sued. (DCP group)*

*When somebody does have a complaint, people would just crumble and never want to go back to work again, but yet they're expected to carry on the next day, and the next day, and the next day, until it's dealt with. (Dentist group 1)*

In contrast, where complaints were discussed by the public, some individuals wondered whether there is a complaints process, others saw a complaints process as part of customer service.

*I mean, you're going to get complaints as a dentist. The patient has had a filling and the filling fell out. You're going to have to deal with complaints. So I think customer service is actually really central. (Public group 2)*

#### 5.5.3 Social media

Social media was discussed in every focus group. The discussions focused predominantly on the potential risks: being accused of inappropriate behaviour for interacting with patients or students on social media, patients finding evidence of a night out, and photos and complaints spreading very quickly.

*If you've got a patient who's had a bad experience or they feel they didn't like something about your practice or you, and that's on social media, that can start a big ripple effect and can affect somebody's career. (Public group 1)*

Some older participants stated that they do not engage with social media. There was also recognition that for the younger generations, communicating via social media is second nature. Social media was also noted as a positive platform to advertise the business.

#### 5.5.4 Attire

Appearance and clothing were discussed more in the dental groups than the public groups. Dental professionals agreed that appearance matters to patients and the general opinion was that wearing a uniform creates a good impression. There was also recognition that there has been a shift in the perception of tattoos, piercings, and bright hair colours: while these were considered clearly unprofessional in the past, they are becoming more acceptable, although some patients are still put off by such forms of self-expression. However, wearing 'too short skirts' was still seen as unprofessional. There was disagreement about trainers, with a recognition that not everyone would be judged equally for wearing trainers.

*Somebody who might be offended by somebody who's got full body tattoos, and the next person doesn't really care, because it's about what that person does, not what they look like. (DCP group)*

*At the dental hospital there'd be some consultants in their comfortable Nike trainers. And actually, the patient has a respect for that dentist, and they're comfortable in what they're doing. I'm not going to be ageist or anything but there's a bit of seniority as well... If the extraction was potentially done quicker and more comfortably but it was someone in their early twenties wearing Nike trainers, actually, it could be more of an issue. (Dentist group 4)*

Several participants noted cross-infection standards, which were viewed positively. This posed restrictions on appearance in terms of wearing items that can become dislodged such as jewelled rings, false eyelashes, and nail polish.

The patients were vaguer about their expectations, saying that a dentist should look smart, groomed, and clean. Some wanted to see uniforms, while others stated that they have never considered this issue or had no opinion about it.

*I would not want a dentist to come in their day clothes just to do an operation on my teeth. I think they ought to have something nice and clean and fresh and also wear a mask. (Public group 1)*

#### 5.5.5 Switching dentist

The dental focus groups talked about patients switching dentists as a threat to be avoided and a reason to maintain a good reputation. Some participants in the public groups shared narratives of switching dentist for various reasons, some relating to professionalism (lack

of hygiene, communication problems, or unsuccessful treatment). However, in the group where this topic was discussed the most, participants also asked whether surgeries take note of the patients who have left. Furthermore, some participants expressed their confusion about the process of switching dentists (within a practice).

*You're stuck with one doctor's practice if you're lucky enough to get in, but you can choose to go to different dentists. So as a dentist you've got to maintain that good reputation, haven't you? (Dentist group 1)*

*I've never seen in any dentist, the names of other dentists, or which dentist you've got a choice of, if you don't happen to like yours or something. Can you switch to one of the other dentists? You're just, sort of, assigned a dentist. (Public group 2)*

### 5.5.6 Hygiene

The issue of hygiene was predominantly discussed by the public. In the dental groups, it was mentioned as something important to the public, or examples shared where a colleague had poor hygiene. Instances where infection control were mentioned by the dental groups were coded for *safety* rather than *hygiene*. The public groups agreed that they expected good hygiene and cleanliness, both personally and in the surgery space.

*For me I'd be looking for a clean and tidy surgery to start with and the same would apply to the dentist or hygienist. And I have left surgeries because I thought I'm not staying here just because things are grotty and mouldy on the walls and things. (Public group 1)*

### 5.5.7 Time keeping

Time keeping was mentioned 10 times in one of the dentist groups and once in three other groups. In the dentist group where it was repeatedly discussed participants debated whether a dentist is expected to stay late in order to complete treatment. There were also complaints about members of the team being habitually late.

*Well I had a patient turn up 20 minutes late for an appointment... Where do you draw the line? When do you say, sorry I can't do it? (Dentist group 1)*

### Summary points – lapses

There were extended discussions about different kinds of lapses, which contribute to defining the boundaries of professionalism. The focus group analysis supports the idea that the public is primarily concerned with what happens in a dental appointment. The public were concerned bothered about practice and practitioner hygiene and cleanliness. The dental groups were more concerned about behaviour outside of the workplace than the public. Drinking alcohol was generally seen as less acceptable for dentists than some other professional groups, for example lawyers. No one suggested that dental professionals should be teetotal, but there was a clear sense of the need for care (for example, avoiding excessive drinking in public and confining drinking to weekends). In contrast, drugs taking was more clearly unprofessional because of its illegal status. Dentists also seemed more troubled by interactions with members of the public outside of the workplace.

Social media was primarily discussed as risky space where inappropriate behaviours may be revealed to patients. There was acknowledgement that social media is unavoidable for younger generations, but there was very little said about positive uses of social media.

Dental groups presented complaints as a serious issue facing dentists and talked about 'defensive dentistry' and a 'climate of fear'. However, the public gave very few reports of making complaints.

Appearance and clothing were discussed more in the dental groups than the public groups. Dental professionals agreed that appearance matters to patients and thought that wearing a uniform, for

example, creates a good impression and recognised a shift in the perception of tattoos, piercings, and brightly coloured hair. The patients were vaguer about their expectations, wanting a dentist to look smart, groomed, and clean.

## 5.6 Theme 4 – Contexts

The codes in this theme cover a variety of factors that shape professionalism in dentistry as displayed in Table 14. Participants made comparisons with healthcare and other professions. There were also discussions about paediatric dentistry, cosmetic dentistry, the surgery space, and the expectations of different generations and cultures. These topics elicited a wide range of opinions. In some cases, there was no agreement even within a focus group.

*Table 14: Codes within the contexts theme, by group*

Code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Healthcare (39)	4	2	0	4	3	4	5	7	6	5
Children (34)	0	0	1	2	6	1	0	3	13	8
Other professions(32)	1	1	3	4	4	3	2	7	1	6
Generations (26)	0	4	2	5	1	3	6	2	0	3
Surgery Space (14)	0	0	0	0	0	0	0	4	7	3
Cosmetic (13)	0	1	1	1	1	0	1	1	3	4
Culture (12)	0	0	1	7	3	0	1	0	0	0

### 5.6.1 Healthcare

There were a range of points made about the similarities and differences between dentistry and other healthcare professions. Overall, both dental and public groups noted that professionalism is very similar in dentistry and medical professions.

*I would imagine it's [professionalism] the same as GPs to be honest with you, because you are disclosing all your medical information, aren't you? (Public group 1)*

However, there were also some distinctions. Dental groups noted that complaints are more common in dentistry, they are not seen as part of the NHS, and that patients have greater expectations because they pay for treatment. The public groups focussed on their experiences with the two general practice environments (medical and dental). They noted that in their experience GP medical appointments were shorter and harder to get.

### 5.6.2 Children

Treating children was mentioned less often in the dental groups compared to the public groups. The dental groups indicated that treating children was more demanding than dealing with adult patients. For parents, the experience of taking their children to the dentist was very important in forming their opinion. The public also talked about their bad experiences of going to the dentist as children.

*My son went in one day and he hadn't cleaned his teeth properly when he was fourteen. And the dentist was very, very unhappy about it. He got into a filthy temper with my son... And he said there's no way I will be referring you for your brace... I went to somebody else and she went, 'you're about a year behind where you should be. I'm going to refer you for a brace. I'm going to refer you urgently'. And he had a brace in three months of seeing the new dentist. So that*

*other chap for some reason had a completely different view on my son's dental situation, to the people that we're now with. (Public group 1)*

### 5.6.3 Other professions

The focus groups provided comparisons with other professions in a similar manner to the scoping interviews. Lawyers were seen as comparable in terms of charging the public for meetings but were also seen to have a much stronger drinking culture than dentists. The aviation industry was referred to as the 'gold standard' in terms of training, ensuring safety, and customer service. Shop assistants were also mentioned as a group providing customer service. Teachers and financial advisors were cited as examples of other groups who should not be seen drinking, especially on social media. In contrast, builders were framed as 'someone you could have a pint with'. Politicians were mentioned in the context of being careful about social media and the police in the context of avoiding public confrontations (road rage incidents) while off duty. These comparisons reflect the aspects that were highlighted by the other codes: the issue of paying for treatment, interacting with patients in an appropriate manner, being publicly recognisable, and working in a position that requires trust from the public.

*I was going to say for any business. So a financial advisor. If you saw a financial advisor getting drunk and being, you know, not very professional would you go to him? No... You know, to earn that trust for someone in the public you've got to act professionally. Otherwise you won't get that business. (Dentist group 1)*

### 5.6.4 Generations

The dental groups talked predominantly about different generations of dentists, with a few mentions of different generations of patients. They noted differences in training, attitudes to social media, communication skills, and attitudes to self-presentation. In the public groups, participants shared conflicting personal opinions of younger and older dentists.

*When you become older you can become more cynical, more arrogant and more impatient and I find that in myself now. I'm kind of like, I've been here so many times before and you know, let's just cut to the chase in this. Sometimes maturity is an advantage and experience is an advantage, and then sometimes it's completely the opposite. (Dentist group 3)*

### 5.6.5 Surgery space

The public groups discussed the buildings and rooms of the surgeries they had visited. Positive evaluations were linked to cleanliness, tidiness, a 'nice setting', and privacy. Patients were deterred by mouldy walls, old houses, back streets, and 'threatening instruments'.

*Unfortunately, a lot of the dental practices are in old houses that have been converted. The reception is put in a place where everybody can hear your business, and sometimes I don't think they think about it. (Public group 2)*

### 5.6.6 Cosmetic treatments

The ways in which cosmetic dentistry has been portrayed in the media and the potential impact on the relationship between dental professionals and their patients is described above (Holden et al 2019). The dental groups suggested that there is increased demand for cosmetic treatments. None of the public participants admitted to being interested in cosmetic treatments, although they were also under the impression that such treatments are becoming more common.

*You know a lot of Botox is going on in dental practices. There is a lot of invisible braces going on now... So from a professional point of view... I mean I don't know. It's a difficult one. There's a lot more going on in dental practice now.*  
(DCP Tina)

### 5.6.7 Culture

The dental groups mentioned that patient expectations are culturally shaped. To ensure appropriate interactions, dentists were seen as needing to be aware of cultural differences and changes.

*You've got to be respectful, caring, and empathetic. It doesn't matter what culture they are, or what age they are. (Dentist group 1)*

#### Summary points – contexts

The codes in this theme cover a variety of factors that shape professionalism in dentistry. Participants made comparisons with healthcare and other professions. Overall, both dental and public groups noted that professionalism is very similar in dentistry and medical professions (and other professions, such as teaching) that requires public trust.

There were also discussions about paediatric dentistry, cosmetic dentistry, the surgery space, and the expectations of different generations and cultures. For parents, the experience of taking their children to the dentist was very important in forming their opinion. Demand for cosmetic treatments (e.g. Botox) was noted as becoming more common. The public wanted clean surgeries and were deterred by mouldy premises, old houses and back streets. The dental groups talked predominantly about different generations of dentists, noting differences in training, attitudes to social media, communication skills, and attitudes to self-presentation. To ensure appropriate interactions, dentists were seen as needing to be aware of cultural differences and changes.

## 5.7 Theme 5 – Learning and development

Most of the sub-themes in this category were discussed exclusively by the dental groups, as displayed in Table 15. The exception is safety, which was also discussed by the public.

*Table 15: Codes within the learning and development theme, by group*

Code (tot)	DCP Olivia	DCP Tina	DCP group	Dentist 1	Dentist 2	Dentist 3	Dentist 4	Public 1	Public 2	Public 3
Safety (41)	0	0	7	6	5	7	5	6	3	2
Clinical competence (24)	7	1	1	9	1	3	2	0	0	0
Challenges (21)	0	0	4	8	3	0	6	0	0	0
Insight (15)	1	3	3	2	3	2	1	0	0	0
Learning by observing (10)	0	1	0	4	1	2	2	0	0	0

### 5.7.1 Safety

Dental groups indicated that infection control is the primary safety issue. In one of the groups, one participant kept stressing that the GDC should not be concerned with anything outside of patient safety. The public talked about safety in terms of knowing the risks associated with certain procedures and being in 'safe hands'.

*If I put myself as a patient... what do I expect from my dentist? I expect him to adhere to the cross-infection standard. (Dentist group 2)*

*You want to have that feeling of, you're in safe hands and it's calm, and it's welcoming. (Public group 1)*

#### 5.7.2 Clinical competence

Clinical competence was mentioned in every dental group, but it was not discussed in detail. It was presented as a key facet of professionalism, with the caveat that competent dentists can still make mistakes.

*I think persistent clinical issues [indicate lack of professionalism]... You can always make a mistake at some point. And that shouldn't be your defining moment of your career. (Dentist group 4)*

#### 5.7.3 Challenges

Dental groups presented a range of challenges they must deal with. In terms of other professionals, there were complaints that incoming dentists are not getting appropriate training in what older generations see as 'the basics'. There were also questions about challenging unprofessional behaviours of others in the practice, especially if there is a difference in hierarchy. Regarding patients, some noted that seeing a wide range of patients makes it difficult to fulfil everyone's expectations. There were also anecdotes shared about patients insisting on cosmetic treatment when it is not appropriate, or in the case of under 18s, illegal. Furthermore, social media was seen as a difficult area to navigate. Finally, there were also complaints about regulations, financial pressures, the 'climate of fear', mistrust between the profession and the GDC, and the toll of working on short-term contracts and national recruitment.

*As a DCP, as a professional, which we all are, if you're still an employee of a dentist it's very difficult potentially to be the professional that you may want to be when your employer is calling the shots. He's pulling strings. He's dictating your ways of work, etc. etc. (DCP group)*

#### 5.7.4 Insight and reflection

Insight was mentioned in all the dental groups as a key aspect of professionalism. Reflection was viewed as something that is encouraged throughout dental training, but necessary to continue after registration.

*Initially when you're younger you might think 'oh my goodness, so-and-so has complained'. But later on you might think 'well, right. What have they complained about? What's the issue?' And it's that whole process of going through that and really coming out the other end. (Dental group 4)*

#### 5.7.5 Learning by observing

All dentist groups and Tina put forward the idea that young dentists learn how the job is done by observing their seniors, picking up good and bad habits equally easily. It was argued that senior dentists need to be more careful of their behaviour for this reason.

*I noticed in my own group, my colleagues would be so different to me just because of their trainer being different. The treatment options, professionalism, how they speak to their patients, how well they know their patients. It's just so different, and it's so dependent on who your trainer is. (Dentist group 1)*

### Summary points – learning and development

Most of the sub-themes in this category were discussed exclusively by the dental groups. The exception is *safety*, which was also discussed by the public. The public talked about safety in terms of knowing the treatment risks and being in 'safe hands'. In dental groups, clinical competence was mentioned as a key facet of professionalism. Challenges to professionalism were noted in dental groups including calling out the unprofessional behaviours of others, seeing a wide range of patients and fulfilling everyone's expectations, patients insisting on inappropriate cosmetic treatment and navigating social media. Insight and reflection were viewed as important throughout dental training and professional practice. All dentist groups noted how new dentists learn from observing seniors, picking up good and bad habits equally easily.

## 5.8 Summary

All three groups of participants highlighted interactions between dental professionals and patients as the most important element of professionalism. This was stated explicitly by several participants but was also the most common code in the focus groups. The second most common code was different for each group: for DCPs it was *working in a team*; the dentist groups tied *complaints* and *outside of workplace behaviour*, followed closely by *financial motivation*; and the public focused on *financial motivation*.

1. In this final section, we revisit the summary points and map them to the questions of interest.

In brackets, we cross-reference additional questions that summary points address. In particular, there is extensive cross-referencing between questions 1 and 2, and several of the findings relating to question 4 also address questions 1 and 2.

*Research Question 1: What aspects of professionalism does the public expect from dental professionals and why are these perceived as important?*

- Communication was widely discussed in all groups. Good communication was considered a very important aspect of professionalism. Empathy, compassion, politeness and friendliness helped patients to feel treated as a person and making conversation was seen as instrumental in putting patients at ease. It was also highlighted that patients want clear explanations of treatment options without being overwhelmed (2). Examples of poor communication were described as, being unclear, robotic, rude, condescending, rushed, overly familiar and not respecting privacy (2). The importance of dentists building rapport and trust with patients was recognised. The public and professionals shared the view that dentists should be formal with patients, at first, but may become more informal over time (2). The dental focus groups also shared potential communication challenges, for example, managing the anxious patient or a confrontational patient (2). Demand for cosmetic treatments (e.g. Botox) was noted as becoming more common (2).
- Dental groups implied that they work in patients' best interests but are nevertheless seen by some as focused on the business aspect of practice because of a small minority of dentists who prioritise profit (2). Members of the public were indeed concerned with dentists working for profit, although they did not report any stories which directly supported this (2.) The public gave very few reports of making complaints.



- The focus group analysis supports the idea that the public is primarily concerned with what happens in a dental appointment. The public talked about safety in terms of knowing the treatment risks and being in 'safe hands' (2,4). For parents, the experience of taking their children to the dentist was very important in forming their opinion. The members of the public were concerned about practice and practitioner hygiene and cleanliness (2). They wanted clean surgeries and spaces that allowed for privacy, and were deterred by mouldy premises, old houses and back streets (2).
- The dental groups were more concerned about behaviour outside of the workplace than the public. Drinking alcohol was generally seen as less acceptable for dentists than some other professional groups, for example lawyers. No one suggested that dental professionals should be teetotal, but there was a clear sense of the need for care (for example, avoiding excessive drinking in public and confining drinking to weekends) (2). In contrast, drugs taking was deemed more clearly unprofessional because of its illegal status (2). Dentists also seemed more troubled by interactions with members of the public outside of the workplace (2).
- Appearance and clothing were discussed more with the dental groups than with the public groups. Dental professionals agreed that appearance matters to patients and thought that wearing a uniform, for example, creates a good impression and recognised a shift in the perception of tattoos, piercings, and brightly coloured hair, with views becoming more lenient (2). The patients were vaguer about their expectations, wanting a dentist to look smart, groomed, and clean (2).
- Social media was primarily discussed as risky space where inappropriate behaviours may be revealed to patients (2). There was acknowledgement that social media is unavoidable for younger generations, but very little said about positive uses of social media (2,4).

*Research Question 2: How can aspects of professionalism be categorised?*

- For many in the dental groups, clinical competence was an assumed aspect of professionalism (1).
- Distinction was made between behaviour in the workplace and outside of the workplace. Members of the public were much less concerned than the dental team members about behaviour outside of the workplace. Ethics and values were mentioned in the public groups only in relation to specific examples of questionable behaviour (1).
- Dental groups discussed the impact of regulations, financial pressures, and isolation on professionalism. They presented complaints as a serious issue facing every dentist and talked about 'defensive dentistry' and a 'climate of fear' (1,4).

*Research Question 3: Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals?*

- There was some disagreement on whether DCPs should meet the same standards of professionalism as dentists. Some argued that lower standards of professionalism could be applied to dental nurses; others that standards should be applied equally across the team. While the dental groups discussed the roles of DCPs, patients focused on the role of the receptionist as their first point of contact.

- Participants made comparisons with healthcare and other professions. Overall, both dental and public groups noted that professionalism is very similar in the dental and medical professions (and other professions, such as teaching) that requires public trust.

*Research Question 4: The teaching of professionalism – how does the undergraduate curriculum prepare students to meet professionalism expectations and how is this evidenced?*

- The dental groups talked about different generations of dentists, noting differences in training, attitudes to social media, communication skills, and attitudes to self-presentation (1,2).
- Challenges to professionalism were noted in dental groups including calling out the unprofessional behaviours of others, seeing a wide range of patients and fulfilling everyone's expectations, patients insisting on inappropriate cosmetic treatment and navigating social media (1,2).
- To ensure appropriate interactions, dentists were seen as needing to be aware of cultural differences and changes (1,2).
- In the dental focus groups, there were discussions about working together as a team and joint responsibility in delivering good care. By implication, these represent suggestions for inclusion in teaching about professionalism.
- There were discussions about whether and how communication skills can be learned. Some dental professionals thought that communication skills are innate, but others discussed the value of education and training. Members of the public were not knowledgeable about whether dental professionals received formal communication training but thought they should do (1).
- Insight and reflection were viewed as important throughout dental training and professional practice. All dentist groups noted how new dentists learn from observing seniors, picking up good and bad habits equally easily.

## PART 6 – KEY FINDINGS FROM THE DELPHI PROCESS

### 6.1 Introduction

A modified Delphi method for was employed in order to extend the reach of the focus groups and to seek a consensus on how professionalism is defined (RQ2) and the behaviours and attributes it encompasses within the dental profession (RQ1). However, our intention was not to produce an objective list of behaviours or attributes of the dos and don'ts of professionalism in dentistry. Rather, we sought to identify clearly defined areas of agreement and lack of consensus, where professional life separates from private life and how views might vary by stakeholder group (RQ3).

### 6.2 Methods

#### 6.2.1 *The survey*

The survey comprised 53 statements relating to various behaviours and attributes of dental professionals. These statements were grouped into 27 items relating to 'unprofessional behaviours' and 26 items relating to 'professional behaviours'. The detailed survey is available in Appendix 5. The statements were further grouped into sub-categories:

- Unprofessional Behaviours
  - Workplace Behaviour
  - Public Behaviour (i.e. those that might be witnessed by members of the public)
  - Private Personal Behaviour (i.e. those that would not typically be witnessed by members of the public)
- Professional Behaviours
  - Interactions with Patients
  - Workplace Appearance and Behaviour
  - Public Behaviours
  - Private Behaviours

For the statements in the unprofessional behaviours group, participants were asked to indicate the extent to which they judged the behaviour or attribute to be unprofessional in dental professionals. The response options were 'not unprofessional', 'moderately unprofessional' or 'highly unprofessional'. For the statements in the professional behaviours group, participants indicated whether they found each behaviour or attribute to be either 'not necessary', 'desirable' or 'essential' in dental professionals.

Consensus was defined whereby 70% or more of participants provided the same response option to a given statement. Statements that did not reach consensus in Round 1 of the survey were included in the second round. In this second round, to inform their response, participants were provided with an anonymous aggregate of the results for these statements in Round 1. Both rounds of the survey also included open questions to allow participants to elaborate their views.

#### 6.2.2 *Distribution*

We set out with a target of 100 responses from participants across the key stakeholder groups, namely, members of the public, dental registrants and policymakers. The survey was disseminated through a number of key individuals who circulated the invitation to

their relevant networks. This included all the Deans of Dental Schools across the UK, representatives of the Royal Colleges in England, Edinburgh and Glasgow, and a representative at COPDEND who circulated to all Postgraduate Deans and Directors throughout the UK. Members of the research team also distributed the survey through their various communication channels. Social media platforms (Twitter and Facebook) were utilised to reach a wider public audience and also dental related accounts or pages.

Round 1 was open between 13/11/19 and 30/11/19. Results were aggregated and Round 2 was open from 9/12/19 until 24/12/19. A third round was not undertaken.

### 6.3 Results

We begin with an overview of the results from Delphi in terms of responses across the two rounds and the demographics of participants. Following this we present the key results in four key sections:

1. Results from Round 1: here we present the results from Round 1 of the Delphi in terms of those items that reached consensus and those that did not and were subsequently distributed in Round 2.
2. Results from Round 2: here we present the results from Round 2 in terms of the additional items that reached consensus. We also present the remaining items without consensus and draw on participants' open text responses to elicit further understanding.
3. Comparison of Consensus across Professionals: here we analyse participant responses according to role. We look specifically at members of the public, dentists and DCPs in order to explore similarities and differences in response.
4. Comparison of Consensus across Age Groups: here we analyse responses according to age group in search of similarities and differences in views across generations.

#### 6.3.1 Demographics

In Round 1 we gathered 1,069 responses, 64.5% of whom were female. In Round 2 we obtained 665 responses (62.2% of those gathered in Round 1), of whom, 62.4% were female. Table 16 and Figure 2 present the responses by participant group. The age groups of respondents are displayed in Figure 3. Totals are less than the total number of responses as not all participants indicated their role. Percentages are calculated based on the total number of responses rather than the total number of participants.

*Table 16: Overview of responses by participant group and round*

Participants	Round 1: n (%)	Round 2: n (%)
Member of Public	55 (5.2%)	29 (4.5%)
Dentist	414 (38.9%)	242 (37.3%)
DCP	310 (29.1%)	200 (30.8%)
Dental Educator or Trainer	153 (14.4%)	100 (15.4%)
Dental Student	63 (5.9%)	29 (4.5%)
Policy Maker or Regulator	28 (2.6%)	21 (3.2%)
Other	42 (3.9%)	28 (4.3%)

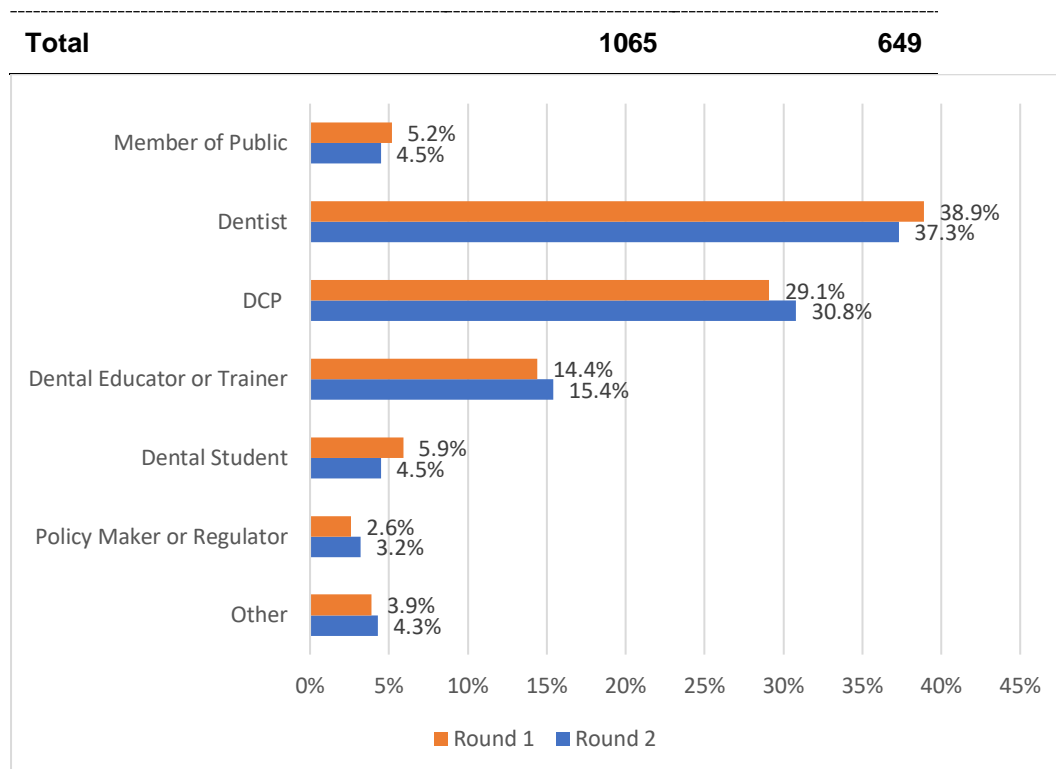


Figure 2: Overview of responses by participant group and round

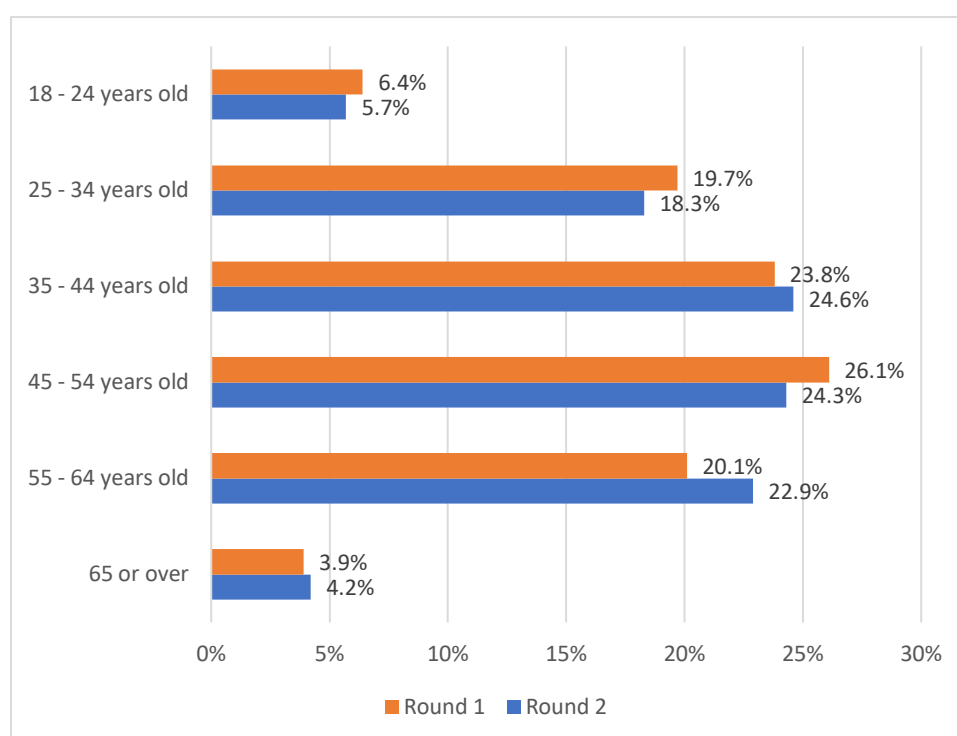


Figure 3: Age demographic of Delphi participants

### 6.3.2 Results from Round 1

After the first round of the Delphi, consensus was reached for 27 of the 53 statements (50.9%). Consensus was proportionately greater for the items relating to professional behaviours (n=17) than those relating to unprofessional behaviours (n=10). These numbers are summarised in Table 17.

*Table 17: Summary of consensus reached in Round 1 of the Delphi*

	Round One	
	Consensus	Non-Consensus
Unprofessional Behaviours	10/27	17/27
Professional Behaviours	17/26	9/26
<b>Total</b>	<b>27/53</b>	<b>26/53</b>

### *Unprofessional Behaviours*

The ten unprofessional behaviours all reached consensus in Round 1 as 'highly unprofessional'. The consensus scores for each of these ten items are summarised in Table 18.

*Table 18: Summary of unprofessional behaviours reaching consensus in Round 1*

Unprofessional Behaviour	Consensus	Percentage
Discriminating against patients on the basis of race, religion, disability, gender, sexuality, etc.	Highly Unprofessional	98.0%
Making sexual advances to a patient in the workplace	Highly Unprofessional	97.4%
Sharing sexually explicit pictures on a public social media page	Highly Unprofessional	88.6%
Cursing and swearing in the workplace within earshot of patients	Highly Unprofessional	85.6%
Use of recreational (illegal) substances when working the next day	Highly Unprofessional	83.8%
Publicly liking a racist joke on social media	Highly Unprofessional	83.7%
Making sexual advances to a patient outside the workplace	Highly Unprofessional	79.3%
Discussing with a patient their medical or dental care in the presence of other patients (i.e. in the reception area)	Highly Unprofessional	77.0%
Providing non-essential antibiotics at a patient's request	Highly Unprofessional	76.6%

#### **Key for Tables 18, 19, 21 & 22:**

Blue = workplace behaviours

Orange = public behaviours

Green = personal private behaviours

Yellow = interactions with patients

Overall, the greatest consensus (highest percentage) among these items was received for the item ‘discriminating against patients on the basis of race, religion, disability, gender, sexuality, age, etc’ where 98.0% of participants deemed this to be highly unprofessional. This was followed closely by ‘making sexual advances to a patient in the workplace’ to which 97.4% of participants deemed highly unprofessional.

### *Professional Behaviours*

In Round 1, 16 of the 17 professional behaviours reached consensus as an essential behaviour; for the remaining one, the consensus was desirable. The consensus score for each of these 17 items are summarised in Table 19.

Only items related to interactions with patients (highlighted in yellow) and workplace appearance and behaviour (highlighted in blue) reached consensus on the first round. Items relating to public behaviours and private behaviours did not reach consensus in Round 1 of the Delphi.

*Table 19: Summary of professional behaviours reaching consensus in Round 1*

<b>Professional Behaviour</b>	<b>Consensus</b>	<b>Percentage</b>
Only using photographs of patients with their permission	Essential	96.1%
Making care decisions on the basis of patient need, not financial reward	Essential	95.1%
Taking care to explain the different treatment options available and gaining consent for the treatment	Essential	94.6%
Listening to a patients’ request and treatment preferences	Essential	93.2%
Explaining to a patient what they are doing and the purpose of their treatment	Essential	92.4%
Fully explaining the cost of treatment	Essential	90.7%
Dealing with accidental breaches of confidentiality immediately and informing the patient(s)	Essential	90.3%
Having good personal hygiene	Essential	89.0%
Treating all members of the dental team with respect at all times	Essential	89.0%
Keeping up-to-date through ongoing education and training	Essential	88.0%
Politely but firmly managing a patient who is being abusive to staff	Essential	84.6%
Being familiar with the most up-to-date requirements for confidentiality and data storage	Essential	84.5%
Consistently seeing patients on time	Desirable	83.4%
Treating patients as you, or a close family member, would like to be treated	Essential	78.8%

Being a good communicator with all types of patients, even 'difficult' ones	Essential	76.6%
Having a good knowledge of other dental professionals' roles and duties	Essential	70.6%
Reflecting on their own knowledge and seeking out training to improve it	Essential	70.0%

The item that achieved the greatest consensus among participants was 'only using photographs of patients with their permission' to which 96.1% of participants felt this was essential (see Table 19). It is notable that 39 participants (3.7%) deemed this only a desirable behaviour and two participants (0.2%) felt this was not necessary. This item was followed closely by 'making care decisions on the basis of patient need, not financial reward' to which 95.1% of participants deemed this essential.

In broader terms, it is evident that the items that were most commonly cited as being an essential attribute of dental registrants were those relating to respect for and communication with patients, as well as general etiquette.

### 6.3.2 Results from Round 2

After Round 1 of the Delphi, the 26 statements that did not reach consensus (17 unprofessional behaviours and 9 professional behaviours) were included in the second round of the survey. To inform their rating, participants were provided with an anonymous aggregate of the results for these statements from Round 1.

Following the second round, an additional eight items reached consensus, five of these related to unprofessional behaviours and three to professional behaviours. However, 18 items did not reach consensus following the second round. These results are summarised in Table 20.

*Table 20: Summary of consensus reached in Round 2 of the Delphi*

	Round 2	
	Consensus	Non-Consensus
Unprofessional Behaviours	5/17	12/17
Professional Behaviours	3/9	6/9
<b>Total</b>	<b>8/26</b>	<b>18/26</b>

### *Unprofessional Behaviours*

The consensus results following Round 2 for the five unprofessional behaviours are summarised in Table 21. Again, these were all deemed to be highly unprofessional and the greatest consensus in the second round was found for the item 'being rude in public about dental colleagues' which 91.6% of participants deemed highly unprofessional.

*Table 21: Summary of unprofessional behaviours reaching consensus in Round 2*

Unprofessional Behaviour	Consensus	Percentage
Being rude in public about dental colleagues	Highly Unprofessional	91.6%



Being convicted of tax fraud	Highly Unprofessional	90.8%
Talking about work on public profiles on social media	Highly Unprofessional	83.1%
Use of recreational (illegal) substances when not working the next day	Highly Unprofessional	81.0%
Being convicted of a drink driving offence	Highly Unprofessional	77.9%

### *Professional Behaviours*

The consensus results following Round 2 for the three professional behaviours are summarised in Table 22. It is apparent that the consensus scores for these items were lower than the unprofessional behaviours listed in Table 6.

*Table 22: Summary of professional behaviours reaching consensus in Round 2*

Professional Behaviour	Consensus	Percentage
Wearing a dental uniform (e.g. dental tunic)	Essential	75.5%
Behaving politely at all times in public	Desirable	71.9%
Sharing learning from training with colleagues	Desirable	70.8%

Of the 18 statements which did not reach consensus, 12 related to unprofessional behaviours and six related to professional behaviours. Before exploring these items in detail, we first report the specific changes that took place between Round 1 and 2 of the Delphi.

### *6.3.3 Changes between Rounds*

From a visual inspection of the results from Round 1 and Round 2 of the Delphi, it was apparent that participants generally appeared ‘less tolerant’ in the second round. That is, there was a shift towards unprofessional behaviours being rated ‘highly unprofessional’ and professional behaviours being rated ‘essential’.

We treated the response options as ordinal data where the highest value represented either ‘highly unprofessional’ or ‘essential’ as shown in Table 23.

*Table 23: Ordinal coding of response options for unprofessional & professional behaviour items*

Value	Unprofessional Behaviours	Professional Behaviours
1	Not unprofessional	Not necessary
2	Moderately unprofessional	Desirable
3	Highly unprofessional	Essential

To explore the significance of this shift we computed Wilcoxon Signed-Rank tests on the eight statements that did not reach consensus in the first round but did after the second round. The Wilcoxon Signed-Rank test compares the responses of individual participants across Round 1 and Round 2 to identify if and how their responses changed. Sign tests were computed for items where median scores did not show a normal distribution.

All but one item showed a statistically significant median increase on the second round as indicated by the p value. A summary of these results is presented in Table 24.

A positive rank is yielded when a participant rates an item higher, i.e. more unprofessional or more essential in the second round than they did in the first round. A negative rank is yielded when a participant rates an item lower, i.e. less unprofessional or less essential in the second round than in the first round. A tie is yielded when their view does not change across rounds.

For example, for the item 'talking about work on public profiles on social media', 178 participants felt this was more unprofessional in the second round than they previously stated in the first round of the Delphi. Alternatively, 26 participants felt this was less unprofessional in the second round than they previously reported in the first round, and 438 participants did not change their view.

*Table 24: Summary of Wilcoxon Signed-Rank tests*

Item	Positive Ranks N (%)	Negative Ranks N (%)	Ties N (%)	Wilcoxon Sign Test
Talking about work on public profiles on social media	178 (27.7%)	26 (4.0%)	438 (68.2%)	Z = -10.190 p < 0.001
Being rude in public about dental colleagues	174 (26.9%)	16 (2.5%)	457 (70.6%)	Z = -11.322 p < 0.001
Use of recreational (illegal) substances when not working the next day	162 (25.1%)	22 (3.4%)	461 (71.5%)	Z = -10.247 p < 0.001 (sign test)
Being convicted of a drink driving offence	156 (24.3%)	30 (4.7%)	461 (71.8%)	Z = -9.165 p < 0.001 (sign test)
Being convicted of tax fraud	159 (24.6%)	8 (1.2%)	480 (74.2%)	Z = -11.607 p < 0.001 (sign test)
Wearing a dental uniform (e.g. dental tunic)	149 (23.0%)	41 (6.3%)	458 (70.7%)	Z = -7.838 p < 0.001
Behaving politely at all times in public	94 (14.7%)	121 (18.9%)	426 (66.5%)	Z = 1.816 p = 0.069 (not significant)
Sharing learning from training with colleagues	88 (13.7%)	144 (22.4%)	412 (64.0%)	Z = -7.701 p < 0.001

From Table 24 it is evident that the last two statements listed showed a greater percentage of negative ranks than positive ranks, that is, participants became more lenient towards these behaviours. These two items reached consensus in the second round on being a 'desirable' behaviour whereas all other items reached consensus on being 'essential' or 'highly unprofessional'.

#### *6.3.4 Summary of Remaining Non-Consensus after Second Round*

Given that after the second round of the Delphi 18 items remained without consensus, we could have progressed a third round. However, review of the open text responses from participants and an awareness of the results from scoping interviews, focus groups and the REA, dissuaded us from doing so. It was evident that many aspects relating to professionalism that we had probed in the Delphi were too context-dependent and circumstantial to warrant a clear-cut definition. Often, participants felt that whether a

behaviour would be considered unprofessional would depend largely on the environment and setting.

Thus, instead of running a third round that would likely not achieve much more consensus, we explored open responses from participants in search of examples of such scenarios and contexts.

Table 25 summarises the 18 items that remained without consensus following two rounds of the Delphi.

*Table 25: Summary of remaining non-consensus unprofessional behaviour items*

Unprofessional Behaviours	Percentage of Respondents		
	Not Unprofessional	Moderately Unprofessional	Highly Unprofessional
Talking about their own personal life with colleagues in the workplace within earshot of patients	15.1	67.5	17.4
Having visible tattoos or facial piercings	56.0	35.5	8.5
Smoking during the workday	17.8	48.6	33.6
Accepting freebies for promoting dental products to patients	23.6	46.4	30.0
Berating a patient for not following oral health advice	9.4	32.6	41.9
Talking about a patient's dental or medical care to co-workers not directly involved in the patient's care	16.1	28.7	55.2
Getting drunk in a public bar during the working week	6.6	25.9	67.5
Getting drunk in a public bar when not working the next day	57.9	32.1	10.0
Cursing and swearing in public	17.7	48.9	33.4
Getting drunk at home when working the next day	8.8	30.4	60.8
Being severely depressed and not seeing a doctor about it	23.0	53.9	23.0
Accepting 'friend requests' from patients via social media, or sending them	7.1	38.9	54.0

It can be seen from Table 25 that three of these items relate to drinking. Many participants reflected on issues around how 'drunk' is defined and often expressed that they felt this is "a variable term" and its relevance to professionalism would depend on the "degree of drunkenness". Several also pointed out that different amounts of alcohol affect people differently:

*It is extremely inappropriate if a staff member is very drunk in a public area, making a nuisance of themselves and known to be a dental health professional/clinician but individuals should have the right to socialise comfortably when they are outside of working hours, as long as they conduct themselves in a way that does not bring ill repute to the profession whilst they are having fun!! (DCP)*

The item relating to accepting freebies yielded highly varying views as seen in Table 10. Registrants pointed out that if “*the produce is safe, effective and appropriate for certain patients*” and they were promoted on an appropriate “*case-by-case basis*” then this would not be an issue. However, “*promoting an ineffective or poor product would be unprofessional*”

The issue of smoking was viewed by some to be “*hypocritical*” of a registrant due to its impact on health. However, others felt that if smoking was done during “*break time, off site*” this would not be considered unprofessional.

Some items were also seen to be problematic in their phrasing, in that they addressed more than one issue. For example, some participants felt that a dental registrant sending a friend request to a patient was more unprofessional than accepting one. Regarding tattoos or facial piercings, often participants felt that tattoos were not an issue, but facial piercings could be a contamination risk.

Table 26 summarises the items relating to professional behaviours with non-consensus. The item ‘having straight, unstained teeth’ raised the same issue of covering two factors. Many participants pointed out that straight teeth are not an indication of oral health whereas stained teeth, if extrinsic, could be.

Regarding criminal records, many participants pointed out that this is highly contextualised and “*depends on the offence*”. Others also highlighted the importance of redemption and that a criminal record “*should not necessarily affect long term professional goals as long as the registrant has remorse and has paid the price*”:

*If a registrant shows a pattern of behaviour and no rehabilitation is able to take place then it is an issue. For a young graduate to be removed from their profession for an error of judgement is an extremely harsh punishment.  
(Educator or Trainer)*

*Table 26: Summary of remaining non-consensus professional behaviour item*

Professional Behaviours	Percentage of Respondents		
	Not Necessary	Desirable	Essential
Keeping political opinions out of discussions with patients	8.6	51.6	39.8
Having neat hair and grooming	2.4	33.7	63.9
Having straight, unstained teeth	40.0	58.4	1.7
Being a positive role-model for younger colleagues	0.8	53.9	45.3
Seeing professionalism as a core belief extending beyond the workplace into everyday life	6.9	60.5	32.6

Having a clean criminal record	5.6	43.5	50.9
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### 6.3.5 Comparison of Consensus across Professional Roles

The next stage of analysis involved exploring whether there were any differences across participants according to their roles. We focused on the extreme ends of the responses ('highly unprofessional' and 'essential') as this was where most of the consensus lay.

However, we explored individual group responses for all items: those that reached consensus, and those that did not.

#### Unprofessional Behaviours

Table 27 and 28 summarise the behaviours or attributes of dental professional that were rated highly unprofessional by members of the public, dentists and DCPs. The items are listed in descending order from the greatest consensus (highest percentage) among members of the public. Table 27 lists items that reached an *overall* consensus and Table 28 lists those that did not.

Table 27: Consensus reached on unprofessional behaviours by role

Behaviours or attributes of dental professionals considered to be <u>highly unprofessional</u>	Percentage of Respondents			
	Public	Dentists	DCPs	Overall
Being rude in public about dental colleagues <b>[Round 2]</b>	96.6	86.7	94.5	91.6
Discriminating against patients on the basis of race, religion, disability, gender, sexuality, age, etc.	94.5	96.4	99.0	98.0
Making sexual advances to a patient in the workplace	94.5	96.6	98.7	97.5
Talking about work on public profiles on social media <b>[Round 2]</b>	93.1	73.3	95.5	83.1
Providing non-essential antibiotics at a patient's request	89.1	59.9	92.5	76.7
Sharing sexually explicit pictures on a public social media page	83.6	80.1	96.4	88.6
Cursing and swearing in the workplace within earshot of patients	83.6	78.0	95.1	85.7
Being convicted of tax fraud <b>[Round 2]</b>	79.3	87.1	94.0	90.8
Publicly liking a racist joke on social media	78.2	74.3	91.9	83.8
Discussing with a patient their medical or dental care in the presence of other patients (i.e. in the reception area)	72.7	69.2	84.5	77.1
Making sexist remarks in public	72.7	62.4	81.8	73.4
Use of recreational (illegal) substances when working the next day	70.9	78.6	90.6	83.9
Use of recreational (illegal) substances when not working the next day <b>[Round 2]</b>	62.1	75.4	88.0	81.0

Being convicted of a drink driving offence <b>[Round 2]</b>	62.1	65.4	91.0	77.8
Making sexual advances to a patient outside the workplace	61.8	76.5	82.7	79.4

For respondents who were dentists, the greatest proportion rating highly unprofessional was seen for the item 'making sexual advances to a patient in the workplace'; and for DCPs, it was 'discriminating against patients on the basis of race, religion, disability, gender, sexuality, age, etc'. These were the two items that reached greatest consensus overall (Table 18). Respondents who were members of the public showed greatest consensus for the behaviour 'being rude in public about dental colleagues'. Interestingly this item is unrelated to them as a patient or their treatment.

Although the 15 items listed in Table 27 reached an overall consensus among participants, there were differences across groups. Of the 15 items, six did not reach consensus among at least one of the three groups: member of the public, dentist or DCP. These items are summarised in Table 28 where a cross indicates that consensus was not reached for this group and a tick indicates that consensus was reached.

*Table 28: Difference in consensus across roles for unprofessional behaviours*

<b>Unprofessional Behaviours – Highly Unprofessional Consensus</b>	<b>Public</b>	<b>Dentists</b>	<b>DCPs</b>
*Making sexual advances to patients outside the workplace	✗	✓	✓
*Providing non-essential antibiotics at a patient's request	✓	✗	✓
*Discussing with a patient their medical or dental care in the presence of other patients (i.e. in the reception area)	✓	✗	✓
*Making sexist remarks in public	✓	✗	✓
*Use of recreational (illegal) substances when not working the next day <b>[Round 2]</b>	✗	✓	✓
*Being convicted of a drink driving offence <b>[Round 2]</b>	✗	✗	✓

Chi-square analyses were computed to test the significance of these differences in the views among the three groups. To reduce the risk of empty cells, particularly in the second round where there were 29 public participants, we collapsed response options from three to two groups. Highly unprofessional remained as its own response option and moderately unprofessional or not unprofessional were combined. All six items (marked with an asterisk) demonstrated significant differences with varying effect sizes.

To identify potential reasons behind such differences, we explored the open text responses where participants were encouraged to expand on their views. Context was often highlighted as an important factor relating to the statements. For example, in relation to providing non-essential antibiotics, there was consensus among the public and DCPs that this was highly unprofessional, but non-consensus among dentists. One dentist highlighted some contextualised examples:

*An unnecessary script of antibiotics for a patient going on holiday? Or an anxious patient delaying care until sedation is available? (Dentist)*

Regarding drink driving offences, there was consensus among DCPs that this was highly unprofessional but not among the public or dentists. One comment from a DCP was:

*A clean criminal record should be a must. We had a dentist that was charged with drunk driving three times and still had a job. Ridiculous, totally ridiculous. (DCP)*

However, dentists seemed to think that such offences were not clear-cut, and that context was important:

*Timing and degree over the limit should be taken into account, e.g. driving to work or directly after significant amounts of alcohol could be considered more unprofessional than 'next day' offenses at the weekend. All illegal but impacting professionalism differently (Dentist).*

Others were of the view that such an event was related to private life and so individuals should not be punished professionally:

*The personal and professional lives should be separated. While a drink driving conviction shows poor judgement or ill health there are already punishments in law for this (Dentist)*

However, a general pattern among the 15 statements was that DCPs appear to be the least lenient in their response to these behaviours, demonstrating the greatest percentage rating for highly unprofessional for almost all the statements.

The remaining 17 statements relating to unprofessional behaviours that did not reach consensus overall are listed in Table 29. It is evident from Table 29 that many of the items receiving the most conflicted ratings were typically (although not exclusively) those that related to private or more personal behaviours.

Table 29: Non-consensus on unprofessional behaviours by role

Behaviours or attributes of dental professionals considered to be <b>highly unprofessional</b>	Percentage of Respondents			
	Public	Dentists	DCPs	Overall
*Accepting 'friend requests' from patients via social media, or sending them <b>[Round 2]</b>	62.1	44.8	58.3	54.0
*Getting drunk in a public bar during the working week <b>[Round 2]</b>	55.2	63.5	74.5	67.5
*Talking about a patient's dental or medical care to co-workers not directly involved in the patient's care <b>[Round 2]</b>	55.2	42.7	66.5	55.2
*Smoking during the workday <b>[Round 2]</b>	55.2	31.5	37.0	33.6
*Accepting freebies for promoting dental products to patients <b>[Round 2]</b>	55.2	26.6	25.3	30.0
Getting drunk at home when working the next day <b>[Round 2]</b>	51.7	58.8	64.8	60.8
*Berating a patient for not following oral health advice <b>[Round 2]</b>	48.3	41.9	70.4	58.1
*Cursing and swearing in public <b>[Round 2]</b>	31.0	24.4	45.0	33.4



*Talking about their own personal life with colleagues in the workplace within earshot of patients <b>[Round 2]</b>	21.4	10.0	28.5	17.4
Being severely depressed and not seeing a doctor about it <b>[Round 2]</b>	20.7	17.2	23.5	23.0
Having visible tattoos or facial piercings <b>[Round 2]</b>	10.3	8.7	10.1	8.5
Getting drunk in a public bar when not working the next day <b>[Round 2]</b>	6.9	11.7	11.0	10.0

Chi-square analyses were computed to search for differences between views of the public, dentists and DCPs on condensed responses to the items.

Significant differences were found for eight out of the 12 items that did not reach consensus. The largest effect size was seen for the item ‘berating a patient for not following oral health advice’. For this item, 41.3% of the public and 41.9% of dentists felt this was highly unprofessional compared with 70.4% of DCPs ( $\chi^2 (2) = 36.006$ ,  $p < 0.001$ ,  $V = 0.277$ ).

It is also of interest that the item ‘getting drunk in a public bar during the working week’ although did not reach consensus overall, did reach consensus as highly unprofessional among DCP participants.

We again explored the open text responses for some explanation. First, to shed light on why these items did not reach consensus overall and why participants displayed such mixed views, and second, to explore the views by respondent group.

Fewer members of the public rated as highly unprofessional ‘getting drunk in a public bar during the working week’. However, this draws us back to the point raised in open responses about ‘drunk’ being an ill-defined term.

The item ‘talking about a patient’s dental or medical care to co-workers not directly involved in the patient’s care’ was often pointed out as being more professional than unprofessional and could be “*in the best interest of the patient*” if seeking advice or gaining a second opinion about a patient’s care:

*You could be speaking to a colleague to ask professional advice/guidance. Some treatment can be complex, and you may want to seek professional opinions before presenting options and giving advice to your patient. (Member of Public)*

However, participants emphasised the importance of maintaining confidentiality and anonymity:

*Sometimes, discussing a patient's care with colleagues is required in order to obtain other opinions and feedback with the aim of providing the best care. Care clearly needs to be taken here to protect individual patient confidentiality. (Dentist)*



### *Professional Behaviours*

Table 30 lists the statements relating to professional behaviours that reached *overall* consensus among participants and the consensus among individual roles. Items are listed in descending order from the highest percentage among members of the public.

Table 19 demonstrated that the items that were most commonly cited as being an essential attribute across all roles were those relating to respect for and communication with patients and general etiquette. Table 30 demonstrates the difference among the different respondent groups. For example, members of the public showed greatest consensus towards members of the dental team 'making care decisions on the basis of patient need, not financial reward' and both dentists and DCPs showed greatest consensus towards 'only using photographs of patients with their permission'.

Table 30: Consensus on professional behaviours by role

Behaviours or attributes of dental professionals considered to be <u>essential</u>	Percentage of Respondents			
	Public	Dentists	DCPs	Overall
Making care decisions on the basis of patient need, not financial reward	96.3	92.5	97.4	95.1
Fully explaining the cost of treatment	93.1	85.7	98.0	90.7
Only using photographs of patients with their permission	92.7	94.2	100	96.1
Taking care to explain the different treatment options available and gaining consent for the treatment	92.7	91.3	99.0	94.6
Dealing with accidental breaches of confidentiality immediately and informing the patient(s)	92.7	83.5	97.4	90.3
Treating all members of the dental team with respect at all times	92.6	81.6	93.5	89.0
Listening to patients' requests and treatment preferences	89.1	91.0	97.4	93.3
Having good personal hygiene	87.3	84.0	94.2	89.1
Politely but firmly managing a patient who is being abusive to staff	83.6	81.8	87.3	84.6
Explaining to the patient what they are doing and the purpose of their treatment	81.8	88.3	98.1	92.4
Being familiar with the most up-to-date legal requirements for confidentiality and data storage	80.0	76.3	94.1	84.5
Having a good knowledge of other dental professionals' roles and duties	78.2	66.6	72.5	70.5
Keeping up to date through ongoing education and training	76.4	85.7	93.8	88.0
Being a good communicator with all types of patients, even 'difficult' ones	76.4	63.8	88.6	76.6
Wearing a dental uniform (e.g. dental tunic) <b>[Round 2]</b>	72.4	66.4	88.5	75.4
Reflecting on their own knowledge and seeking out training to improve it	67.3	65.0	72.4	70.0
Treating patients as you, or a close family member, would like to be treated	65.5	73.1	89.3	78.8
Behaviours or attributes of dental professionals considered to be <u>desirable</u>	Percentage of Respondents			
	Public	Dentists	DCPs	Overall
Consistently seeing patients on time	83.6	88.1	80.8	83.3
Sharing learning from training with colleagues <b>[Round 2]</b>	48.3	74.2	73.4	70.8
Behaving politely at all times in public <b>[Round 2]</b>	75.9	74.3	66.8	71.9

As with the unprofessional behaviours, it was apparent that some items although reached an *overall* consensus, they did not reach consensus among individual groups. This was evident for five items which are summarised in Table 31 where a tick indicates consensus among this role and a cross indicates non-consensus.

*Table 31: Difference in consensus across roles for professional behaviours*

<b>Professional Behaviours – Essential Consensus</b>	<b>Public</b>	<b>Dentists</b>	<b>DCPs</b>
Having a good knowledge of other dental professionals' roles and duties	✓	✗	✓
*Being a good communicator with all types of patients, even 'difficult' ones	✓	✗	✓
Reflecting on their own knowledge and seeking out training to improve it	✗	✗	✓
*Wearing a dental uniform (e.g. dental tunic) <b>[Round 2]</b>	✓	✗	✓
*Treating patients as you, or a close family member, would like to be treated	✗	✓	✓

Of these five items, chi-square analyses revealed significant differences across three of them (marked with an asterisk). The greatest effect size was seen for the item 'being a good communicator with all types of patients, even 'difficult' ones' ( $\chi^2 (2) = 57.284$ ,  $p < 0.001$ ,  $V = 0.272$ ). Among dentists, this item did not reach consensus as essential.

The remaining six items relating to professional behaviours that did not reach overall consensus after the second round are listed in Table 32. We again computed chi-square analyses for the professional behaviour statements that did not reach overall consensus in an attempt to search for differences between views of the public, dentists and DCPs around professionalism. Response options were collapsed from three groups to two to reduce the likelihood of empty cells. The response option 'essential' was kept as its own and 'desirable' and 'not necessary' were combined.

*Table 32: Non-consensus on professional behaviours by role*

<b>Behaviours or attributes of dental professionals considered to be <u>essential</u></b>	<b>Percentage of Respondents</b>			
	<b>Public</b>	<b>Dentists</b>	<b>DCPs</b>	<b>Overall</b>
*Having neat hair and grooming <b>[Round 2]</b>	62.1	51.3	77.0	63.9
*Being a positive role model for younger colleagues <b>[Round 2]</b>	58.6	36.7	50.8	45.3
*Keeping political opinions out of discussions with patients <b>[Round 2]</b>	58.6	28.2	48.0	39.8
*Having a clean criminal record <b>[Round 2]</b>	48.3	43.6	67.5	50.9
Seeing professionalism as a core belief extending beyond the workplace into everyday life <b>[Round 2]</b>	24.1	29.9	27.6	32.6
Having straight, unstained teeth <b>[Round 2]</b>	3.4	2.5	1.5	1.7

Significant differences were found on four of the six statements that did not reach consensus. The largest effect size was seen for the item ‘having neat hair and grooming’ ( $\chi^2(2) = 31.006$ ,  $p < 0.001$ ,  $V = 0.257$ ). This was also the only item that although did not reach consensus overall, did among DCPs. Where 62.1% of the public and 51.3% of dentists considered this to be an essential attribute, 77.0% of DCPs did and who therefore held a consensus.

In an attempt to explore some of the reasoning behind these differences, we turned to the open text responses from participants.

Dentists, the group who collectively, were less likely to deem neat hair and grooming as an essential attribute, had the following comments:

*Neat hair and grooming probably improves patients' perception but ultimately has no bearing on the skill or quality of care a dentist provides. (Dentist)*

*Wearing a dental uniform (e.g. dental tunic) is not essential, you could use clothing which confirms to decontamination guidance. (Dentist)*

Professionalism as a core belief that extends into the everyday life of registrants was an element that did not reach overall consensus. Although not largely apparent from the individual items, the distinction between where a registrant's professional life starts and ends received greatly disparate views among participants in their open responses and evidently, a real lack in consensus.

These disparate views were not only evident between groups but also within them. Some participants felt very strongly towards the importance of a clear separation between professional and private life:

*You seem to be conflicting being good at dentistry with being a good person. Would you prefer a highly moral, useless cardiac surgeon or a talented one with a dubious private life? (Educator or Trainer)*

*I want my dentist to do good dentistry, not to be a paragon of virtue (Public)*

Others however, felt there was a clear overlap between the two and that dentistry is in fact a “life choice”:

*I feel that dental professionals are in a similar category as doctors, teachers, nurses and others who work to look after and help members of the public [...] such individuals should aim to keep a professional manner in both their work and home lives to ensure public confidence in them and in the role they provide. (Dentist)*

However, other participants emphasised the importance of striking a balance and that professionalism is not a matter of one extreme to the next:

*There has to be a limit to how long we are expected to turn our work personality on but I don't mean go out and take drugs and steal cars. (DCP)*

*It's hard to regain any lost trust so how we project ourselves both in and outside of the workplace is very important. There are ways to enjoy life that don't impact on dentistry's reputation. (DCP)*

Some also implied that it was not an issue of divide but felt that in fact professionalism, by its very nature is a mannerism that is always carried with someone:

*I think generally, if you work in a professional manner it flows into other aspects of life, rather than the other way around (DCP)*

*Putting on a good show outside of work is irrelevant - but continuing to care and respect fellow humans makes us congruent and is authentic professionalism in my opinion. (Dentist)*

Nonetheless, it is evident from Tables 27-32, generally speaking DCPs appear to be the most vigilant or stringent, dentists most tolerant or lenient, and the public somewhere in between the two.

### 6.3.6 Comparison of Consensus across Age Groups

We also considered the possibility of a generational divide among responses as well as among roles. To explore this, we condensed the six age groups into three as illustrated in Table 33.

*Table 33: Condensed age groups of participants*

<b>Original Age Group</b>	<b>New (condensed) Age Group</b>
18 – 24 years old	18 – 34 years old
25 – 34 years old	
35 – 44 years old	35 – 44 years old
45 – 54 years old	45 +
55 – 64 years old	
65 +	

We selected particular items that we felt were most likely to reveal disparate views across these age groups. These were generally items that, in a wider sense and beyond dentistry, had evolved with time. These aspects had also been highlighted in participants' open responses and in focus groups.

Such items typically related to appearance (tattoos and piercings), use of social media, and drinking and use of illegal substances. Many of the items we explored had not reached overall consensus after the second round of the Delphi.

At a glance, and from the handful of items that were explored, it is apparent that those participants in the 45+ age group were generally the most vigilant or stringent in their views. The items investigated are listed in Table 34; those that showed significant differences between age groups are marked with an asterisk. Although effect sizes were small, the largest was seen for the item 'getting drunk in a public bar during the working week' ( $\chi^2 (2) = 22.765, p < 0.001, V = 0.188$ ).

We also looked at the item 'being a positive role-model for younger colleagues' in order to identify whether this was held in higher regard among the younger participants, however no significant differences were seen.

There appeared to be no significant differences in responses regarding professionalism as a core belief that extends beyond the workplace.

Table 34: Differences across age groups

Behaviours or attributes of dental professionals considered to be <u>highly unprofessional</u>	Percentage of Respondents			
	18-34	35-44	45+	Overall
*Having visible tattoos or facial piercings [Round 2]	3.8	2.5	13.3	8.5
*Getting drunk in a public bar during the working week [Round 2]	62.8	58.1	73.3	67.5
*Getting drunk in a public bar when not working the next day [Round 2]	2.6	6.3	15.5	10.0
*Talking about work on public profiles on social media [Round 2]	78.6	76.9	88.0	83.1
Getting drunk at home when working the next day [Round 2]	63.5	57.5	60.6	60.8
*Use of recreational (illegal) substances when not working the next day [Round 2]	75.6	76.9	85.8	81.0
Accepting 'friend requests' from patients via social media, or sending them [Round 2]	56.4	51.3	54.8	54.0
Behaviours or attributes of dental professionals considered to be <u>essential</u>	18-34	35-44	45+	Overall
*Having neat hair and grooming [Round 2]	54.5	61.9	69.8	63.9
Being a positive role-model for younger colleagues [Round 2]	45.5	40.9	47.9	45.3
Seeing professionalism as a core belief extending beyond the workplace into everyday life [Round 2]	29.5	30.2	36.3	32.6

## 6.4 Discussion

The results from the Delphi reported here provide an overview of the views among key stakeholders towards the nature of professionalism in dentistry.<sup>1,2, 3</sup>

Some aspects appear to be well defined and clear-cut, such as not discriminating against patients or making sexual advances to patients in the workplace. The importance of gaining consent from patients, communicating effectively and making care decisions based on the patient's best interest was also evident from our results.<sup>1,3</sup>

Other aspects are less clear. For example, the appearance and presentation of registrants and where their professional life and personal life begins and ends.<sup>1 and 3</sup>

What is apparent is that many situations are not standardised and are largely contextual. Professionalism is a multifaceted construct and whether an action or behaviour is considered to be unprofessional will depend on a number of different aspects: inter-alia, cultural or religious factors, environment and setting, the observer or individual the action is directed towards and their perception, and whether the scenario was a one-off event or a patterned behaviour.

From comparing the views among different groups (RQ3), namely dentists, DCPs and members of the public, it was evident that generally, DCPs appear to be the most vigilant or stringent around aspects of professionalism. For the majority of items, DCPs more often rated behaviours or attributes towards the extreme ends: highly unprofessional or essential. Dentists on the other hand appeared to be the most tolerant or lenient towards certain behaviours, with more inclination towards not unprofessional or moderately unprofessional, or not necessary or, desirable. The public was subsequently positioned somewhere between the two (RQ1).

The analysis of this survey process, focussed largely on the voices from members of the public, dentists and DCPs. This was done as the majority of responses came from dentists and DCPs and it was also deemed critical to pedestal the patient (public) voice. Statements where there was a high degree of consensus provide an indication of fundamental elements of professionalism in dentistry. Those that did not yield a consensus, in conjunction with the detail provided in open text responses, offer insight into the complexity of many aspects of professionalism and the importance of context.

## PART 7 – CONTRIBUTIONS FROM THE REVIEW OF PREPAREDNESS FOR PRACTICE

The companion report, referred to earlier, on preparedness for practice, provided a series of key findings, some of which are relevant to the findings regarding professionalism. However, we note that the review of preparedness for practice focused on the point of graduation, whilst this report covers professionalism for students, new graduates and established dental professionals throughout the continuum of education and training – lifelong learning.

In the summary of the review, we listed key findings that addressed the four questions. More specifically, the review aimed to address:

1. to what extent are new dental graduates meeting required learning outcomes and is this an effective starting point from which to practise safely?
2. what factors contribute to variance in preparedness for practice, are there specific skills, tasks or knowledge that graduates are achieving or lacking and what evidence demonstrates this?
3. what is the potential impact, on both patients and the profession, of graduates being inadequately prepared for practice?
4. what evidence is there (from dentistry or other healthcare professions) of ways that preparedness for practice has been defined, addressed and evaluated?

We used font styles to indicate the evidence source: in normal print, the REA; *in italics*, the scoping interviews; **in bold**, the GDC conference (November 2019). Where a finding related to one or more of the other research questions, the additional area number is recorded in brackets.

1: Meeting the required learning outcomes and starting to practise safely.

- *It was suggested that students need to be prepared to work with different patient groups in different contexts and be aware that there may be inter-generational differences in expectations (2).* Increasing awareness and managing expectations – do patients know what to expect from dentists? They need to recognise that they are human (3).

2: Where graduates achieve or lack preparedness for practice and factors contributing to variation.

*Specific skills, tasks or knowledge that graduates are achieving or lacking*

- Areas that healthcare/medical undergraduates need to be more prepared are identified in the literature including: wound care, referrals, medicines management and prescribing, diagnosis and treatment planning; delivering emergency care; hand-over; working within a multi-disciplinary team; legal and ethical issues; and managing clinical incidents/errors.

*Factors contributing to variance in preparedness for practice*

- Compared to a discipline-based organisation of teaching, evidence from dental education research suggests that integrated, patient-centred teaching is more effective (4).



- Research with students from other health-related professions found that graduates from problem-based learning programmes were prepared better in communication, team working and dealing with paperwork (4).

### 3: Potential impact of inadequate preparedness for practice

- In addition to demographic changes, societal changes are reported to include a more litigious environment for which students and new graduates need to be prepared to navigate (2). **Alleviating fear of the GDC – need to convey the right message about regulation to new dentists – emphasise what is stated in ‘shifting the balance’ (4).**
- *Interviewees gave attention to attitudes and behaviours that were indicators of preparedness for practice. Two of these related to interactions with others, specifically with patients and in teamwork. Being able to communicate well is an important aspect of preparedness (4). These issues can impact on patients and the profession.*
- *Managing complexity and dealing with uncertainty were also identified as important aspects of preparedness for practice, which can impact on the profession and patient care (4).*

### 4: How preparedness for practice has been defined, addressed & evaluated.

#### *Definitions*

- Preparedness for practice encompasses not only clinical skills but also behavioural, emotional and attitudinal aspects. *Clinical competence was seen as a fundamental aspect of preparedness for practice although interviewees recognised that multiple elements constitute preparedness for practice, including health, mental health and pastoral aspects.*
- **In the process of refining the prescribed learning outcomes (2020/21), the GDC needs to review the definition of a ‘safe beginner’ (1).**
- **Need for clarity of the transition from undergraduate to postgraduate training and the support that is needed along the way. As part of this, there is a need to define the role of the GDC in Foundation Training, and how Foundation Training links to undergraduate training.**

#### *How preparedness for practice has been addressed*

- Studies of different approaches to curricula design have demonstrated beneficial effects of patient-centred, outcomes-based, integrated, problem-based and interprofessional programmes.
- There is much evidence of the value of ‘real-world’, outreach placements in improving *preparedness for practice*. Findings from the UK are replicated elsewhere (Sweden, India). *One of the main reasons why ‘real practice’ experience is important is that it helps students/trainees to learn to deal with complexity and pressure (2).*
- **There is a need for further development of GDC toolkits (or from other organisations), particularly for early foundation dentists.**
- Student/trainee self-reflection supported by constructive feedback can assist *preparedness for practice*. *Regular reflection on practice aids development. To be prepared for practice, students/trainees need appropriate support (including constructive feedback and gradual withdrawal of support through the course of their training).*

*How preparedness for practice has been evaluated*

- Other means of evaluating preparedness include competency-based assessment and self-reflection (1). Self-assessment can be taught and is a skill for life-long learning.

## PART 8 – CO-PRODUCTION ACTIVITIES

### 8.1 GDC Policy and Research Board Workshop

As described in section 2.6, this workshop took place in September 2019 and addressed eight identified questions during two sessions. The details were collated by three team members who facilitated the event. PRB members formed four table-top groups and each group addressed all eight questions during the workshop.

The following information was collected through a series of table-top discussions covering eight topics as described in the methodology section.

#### **1. How would you characterise the GDC's current approach to describing professionalism through its Standards?**

Headline messages – consensus on need for guidance and current standards too prescriptive and need modification. Do the standards allow enough freedom for the individual to make choices? Are we doing enough to instil professionalism in students? Scientists/technicians versus caring professionals

#### **2. What is working well in terms of professionalism in dentistry?**

Consensus that in general dental registrants are very good at being professional and the need to celebrate good practice. Professionalism is an integral part of dental care. GDC interaction with students and registrants is a positive step forward. Need to build on an environment of trust between registrants and the GDC. GDC aiming to shift towards more outcomes-focused less prescriptive approach

#### **3. What is not working well in terms of professionalism in dentistry?**

External 'system' factors were identified as being a barrier to professionalism. The boundary between personal/private space and how professionals should conduct themselves is a grey area e.g. social media. Concern that there is no clear agreed definition of professionalism and that professionalism means different things to different people. Concern that only the minority of registrants valued (respected and understood) regulation. Contradictions – some registrants relying on/wanting prescriptive guidance (confidence/safety net?) and others fighting against it. One size does not fit all.

#### **4. To what extent do you think the GDC's current characterisation of professional standards protect the public, help to maintain confidence in the profession and drive professionalism?**

Concern that there is a lack of engagement with the current Standards. The Standards document comes across as something that the GDC produce as a legal obligation rather than to help drive professional behaviour/standards – not seen as a tool to drive professional behaviour. Concern that current standards may be a hinderance to innovation. Risk that standards may promote fear, rather than professionalism and therefore encourage "defensive dentistry" practices

#### **5. How might the GDC, using the standards they set for registrants, better respond to concerns the public might have?**

Overall improved communication with patients was highlighted as an important measure to addressing any public concerns. Further suggestions included: co-production events with the public about how concerns can be best addressed; educating the public - production of public-facing documents that are clear and accessible, providing information for the public about what might be expected of a dental professional; if a concern/complaint is raised, responding to the public and communication with

registrants was deemed important (GDC); need for clarity of standards driving fitness to practise outcomes.

**6. Thinking about the professional's journey from education into practice and through their career, in what ways can the GDC help develop a common and shared understanding of professionalism at each stage of that journey?**

There was a consensus that there should be a consistent message and engagement throughout the dental professional's journey, starting at the undergraduate level and new registrants - work with education providers across the transition. Reflective practice, peer discussion and interprofessional reviews via e.g. CPD (like the GMC use) were considered valuable. Shared learning and experience for students/trainees (possible 'shadowing' opportunities) for early stage career) should be encouraged throughout. The need to strengthen the advocates of professionalism.

*Documents/guidance:* GDC to regularly review and refresh documents, providing examples of best practice. Standards need to be visible and communicated to the profession. Guidance for employers about what the GDC are doing; revision of learning outcomes, engagement with students/FTs; revision of standards; review admissions procedures, expand the processes used by the PASS group, that support professionals in difficulties; supporting the new registrant (e.g. GMC processes).

**7. What are the emerging professionalism issues and challenges and how do the GDC address these?**

Emerging issues/challenges relating to professionalism were identified as:

- The interplay of NHS contracts and pressures of running a business, with professionalism and the registrant's ability to be a good health professional.
- Division within the profession – interaction between members of the dental team, issues of hierarchy and the difficulty in sharing views.
- Culture and issues of hidden discrimination.
- Challenges to devising principles for professionalism.
- Data protection.

The main suggestion of how to address emerging the issues were strengthening the unity of the profession - all those involved in the profession (stakeholders, regulatory bodies, different members of the dental teams), not just the GDC need to be involved in a shared philosophy and purpose. Need to have a philosophy of sharing experience to address challenges.

*Other suggestions included:*

- Utilising social media to share both good and bad aspects appropriately.
- Raising concerns – need for protection and legal support e.g. in relation to whistleblowing.
- Identify risks of harm to patients and any evidence in relation to professionalism.
- The need to explore the use of tele-dentistry and artificial intelligence in a supportive and productive way.

**8. How would the GDC keep pace with changes and developments as they relate to professionalism?**

A number of potential changes/developments were identified as having an impact on professionalism, namely: technological advancement – social media, growth of tele-dentistry remote prescribing; system changes – NHS contract changes, privatisation of

dentistry, scope of practice, reduced access to services in some areas. Needs were identified in relation to:

- Societal/cultural issues – consumer perception, litigation awareness, patients' and professionals' expectation.
- Mechanisms to ensure that the regulators are up to date with changes that may impact on professionalism e.g. create opportunities for GDC to have feedback from dental teams about how the dental sector is evolving and coming to a shared view of how this might impact on professionalism.

How can the GDC respond to changes in public perceptions of what treatments can be provided by individuals who are not dental professionals and the risk to public safety and confidence e.g. tooth whitening, cosmetics?

*Suggestions on how to improve included:*

- Need to be agile, allow innovation via a simple principle-based approach.
- Employ coders to write algorithms/AI to tell us up to the minute what professionalism means.
- Need commercial awareness to inform future standards.
- Need to engage in horizon scanning for technical changes in clinical care.

## 8.2 GDC 'Moving Upstream' Learning Event

In their publication entitled '*Shifting the Balance*' (General Dental Council 2017), the GDC committed themselves to an agenda of moving the system of regulation 'upstream'. The GDC's proposals in the latest update (2020) on 'moving upstream' include:

1. Development of a 'data and intelligence strategy'.
2. A review of the '*Standards for the Dental Team*' (General Dental Council 2013).
3. An enhanced strategy of engagement and cooperation - supported by an annual report on the profession of dentistry.
4. Relevant and robust evidence informing learning outcomes that are agile and responsive.
5. A quality assurance process for education in dentistry which is based on risk foundations.
6. Guidance and support material to help practitioners trained out-with the UK to move into the UK dental workforce.
7. An enhanced approach to CPD which:
  - links CPD standards to appraisal processes and management of performance
  - encourages 'planning, development and innovation'
  - identifies areas to focus on which are supported with evidence
  - strengthens the use of interactive modes of CPD including peer review/support
  - identifies areas of benefit or risk.

As part of their progress to these reforms, the GDC held a 'Moving Upstream' learning event in February 2020 in London. The event was attended by a diverse audience including dentists, DCPs and members of the public, representatives from undergraduate and postgraduate training institutions, CDOs and a wide range of other relevant stakeholders from dentistry and other healthcare sectors and regulatory organisations.

In introducing the event, Stefan Czerniawski (GDC Executive Director: Strategy) spoke of the need to shift towards prevention rather than reaction to 'regulatory lapses'. One objective is to support patients in resolving concerns. A three-part, chaired Panel discussion followed. We report the first panel and panel 3, here, as they are more directly relevant to professionalism. Further information on the event can be found in Appendix 7.

**Panel 1: Public and Patient Expectations of Professionalism** Chair: Jonathan Cowpe  
ADEE Project Team member (JC)

Panellists, included a recently qualified dentist (1); a public representative (2); an established dental practitioner (also GDC council member) (3); and an established dentist, clinical leadership fellow (4) – standing in for the invited panellist (DCP) who was unable to attend due to flight delays. Members of the panel led responses to specific discussion areas.

#### Professional life vs. private life (1)

Overlap is inevitable and social media blurs boundaries – where does private life start and professionalism end? Social media impacts, include: criticism, marketing, building a client base, display of character. TV programmes, like Bake Off and Love Island have had dentist and doctor contestants, publicly announcing their profession.

#### Expectations of different members of the dental team – are they at a variance? (JC)

The views are not unanimous, among dental professionals or among the public, but there is a recognition of the importance of 'trust' among the team, and between the team and their patients.

#### Role of regulators (3)

GDC has a key role in defining professionalism, protecting the public and maintaining confidence in the profession in parallel. It has a legal duty to set and promote professional standards. The 2013 standards are outdated. It is important that the GDC talk and work with all stakeholders and it is essential that there is a voice from the public. We, as stakeholders can and should influence the GDC. It is important that the GDC speak to individual registrant groups recognising their different scope of practice. The current biggest challenge is the perceived difficulty with engagement. Thus, there is need to encourage widespread engagement in order to produce a workable definition of professionalism

#### Dentistry vs. other professions (2)

In opening this discussion, the Chair (JC) commented on a recent optometry seminar on 'teaching professionalism', held at the School of Optometry, Cardiff University. This was attended by a wide range of healthcare sector educators. In teaching about professionalism, emphasis is given to the positive side of professionalism - the dos rather than the don'ts. Professionalism should initially be taught and learnt by how the profession views professionalism. The influence of the regulatory body and Fitness to Practise issues are introduced later in the course. The perception being that students cope better with what might be perceived as negative issues and this can reduce the 'fear factor' when entering the workplace environment.

The public panellist (RL), commented that the public do not have one single view and expectations are not unanimous. She reflected on research that asks the public to differentiate their expectations across different professions without recognising what she

described as three broad groups of healthcare practitioners: doctors and dentists (held to the highest standards); followed by, for example, pharmacists / osteopaths / chiropractors; and then, acupuncturists / herbalists. The public's perceptions depend on links with the NHS and the level of the 'profession'. However, there are common general expectations; many of these are instinctive- 'I'll know it when I see it' and generally these expectations relate to appearance, environment and communication. She remarked that generational differences are evident across all professions. Complications arise when money is 'changing hands' (consumer vs. patient) and this raises expectations. The commercial aspect of dentistry may reduce trust where there is an assumption that there is a perceived focus on profit. There is also a greater sense of 'mystery' in dentistry, for example 'how do I know that treatment is necessary?' Also, the patient is in a uniquely vulnerable position when in the dental chair. Pain/discomfort and payment are almost guaranteed perceptions or real thoughts.

### Open debate

Points raised during the open debate included:

- It is an impossible task to define professionalism.
- It relies heavily on soft skills We need to move away from a focus on appearance. It is about aligning a moral compass and working to the patient's best interest - 'things you cannot see'.
- Any definition of professionalism needs to be realistic and account for context. It is primarily about having some common sense – if one is questioning whether one should do something, then don't do it, seek advice, reflect.
- Each time a new generation of dentists comes through, things have moved on and the current concept of professionalism becomes redundant. Black and white guidelines do not work, and we should aim to move towards principle-based approach rather than a prescribed list of behaviours.
- Private life is complex, so if you choose to publish your private life on social media then this is no longer private.
- There is also the additional complication of what people post about you, the professional, not just what you post yourself. This is much more out with the control of the registrant.
- The nature of professionalism is multifaceted – challenging patients and/or challenging situations. Many students and newly qualified dentists are having to deal with challenges of which they have no experience.
- NHS treatment and payment options are not clear to either patients or the dentists.
- Dentists are human and will have flaws but is something a patterned behaviour? That is when alarms will ring. Mistakes are expected and acceptable, so long as the individual then reacts appropriately.
- Consent is needed whether money changes hands or not and other professionals could potentially learn from the high standards in dentistry.
- There seems to be a view that doctors are heroes and dentists are the bad guys and this could be related to the financial element - 'money grabbing' dentists. Aligned with this might be the lack of trust among public in relation to cost justification and necessity of treatment – insufficient patient engagement with decision making.
- Cultural relativism is crucial and there is a need to address sensitivity both towards dentists and towards patients, in this respect.
- There are a series of suggested key elements that impact on professionalism and these include unconscious bias, interpretation, perception and expectation. The use

of the term 'lapse' rather than being unprofessional is a valuable way forward. how you react to this lapse and maintain full transparency.

- The importance of learning, training and the transition period from university to moving into the workplace. There are a number of pressures that impact on newly qualified dentists: increased responsibility, additional elements such as safeguarding and whistleblowing. They need improved support and guidance to dispel the 'fear factor' surrounding professionalism and lapses. Students need to be aware of expectations expected of them and the environment they are entering into.
- There is a difference between learnt behaviours and experiential behaviours and this is of particular relevance to non-vocationally trained registrants.
- Public surveys suggest that people have most trust in doctors and nurses and 90% trust in dentists and 89% trust in teachers.

### **Panel 3: Future Challenges in Dentistry**

The feeling that professionals have of being undermined and undervalued needs to change. It would be useful to produce a matrix of risk approaches.

There is perceived 'climate of fear' among dentists, so it is important to keep things proportionate and reduce the culture of 'defensive dentistry'. There is a constant fear of litigation, exacerbated by being bombarded by guidelines and as a result litigation appears to be bigger concern than regulation.

There is a need to nurture undergraduates (UG) and Foundation Dentists (FD), as they enter the 'big bad world' rather than abandon them when they venture beyond foundation training. There are perceptions that UGs and FDs are the gold standard in terms of being suitably supported. However, Associate dentists are disadvantaged particularly where little support is available to them and this can potentiate a culture of 'defensive dentistry'.

It is important to talk more about the good things that are happening. Celebrating these rather than scrutinising and chastising the negative things. Students and young dentists (professionals) are vulnerable to 'horror stories' – positive stories don't make the headlines, negative ones do. There is a need for a shift from a negative focus to a positive one. Defensive dentistry can make it difficult to do the right thing when that isn't what the patient wants.

DCPs should not be treated as one group. They need to grow their voice, which needs to be listened to and responded positively to. There needs to be clarity on how different DCPs are regulated and where the responsibility line lies between the employer and the regulator.

Teamwork is crucial - working together as team. There is a need to better understand individual roles and competence of the dental team, encouraging team-based training and address hierarchical professional boundaries. Rather than separating dentists and DCPs, they should be referred to as registrants. All members of the team are important and need to work together, not individually.

Importance of prevention (being proactive rather than reactive) and common sense. Need to nurture the positive professional image in dentistry and the privilege of being a registrant.



Encourage an ethos of self-regulation: considering competence, risk, environment. Being professional goes beyond clinical knowledge and involves self-regulation and knowing your role and level of expertise and when to refer and ask for help.

Importance of transparency is paramount: explaining risk to patients, giving recommendations, emphasising the consequences if patient doesn't follow advice. Identify whether the working environment supports professionalism. Duty of care for employees must exist, irrespective of funding source and environment.

Dentistry needs to keep up with technological advancements. In turn professionals may be wary of the "google generation". This increasingly has led to a shift in patient expectations – they read up on their symptoms. It is vital to invest time in discussion with patients and communicate appropriately and transparently. It is important to keep records of discussions with patients, the decisions that have been made and why they were made.

The role of listening is very important for the GDC too and there is now evidence of this through their engagement with the profession and their commitment to transparency.

#### Open debate

Points raised during the open debate included:

- Challenges of dentistry - culture of fear (young dentists); knowing limitations and when to ask and refer; patient responsibility for own healthcare; risk course analysis and the five whys.
- 3 'Rs' - share Risks; note Recommendations and consequences; Record
- Leadership training supports managing self-regulation - What is right and how can I make it happen?
- Mentorship should apply across all dental professionals
- Predictable dentistry, but becoming defensive, avoid deskilling
- DCPs – they are distinct groups of professionals: dental nurses and dental therapists form through different training streams
- Dental nurses struggle to know their roles and responsibilities
- Positive professionalism - agreement between patient and practitioner about their care
- Keep up with digital dentistry.

Further details from this event are provided in Appendix 6

## PART 9 – KEY FINDINGS AND CONCLUSIONS

In this final section, we map the main findings to the four areas of interest posed by the GDC in their tendering process. In addition, we have mapped each statement to the part of the project:

- Part 3 - Scoping interviews: *italics.*
- Part 4 - REA: normal print.
- Part 5 - *Focus Groups:* ***bold italics***
- Part 6 - Delphi survey: **bold print**

Where a key finding relates to one or more of the other questions, the additional area number is recorded in brackets.

Research Question 1: What aspects of professionalism does the public expect from dental professionals and why are these perceived as important?

*The public gave very few reports of making complaints. The focus group analysis supports the idea that the public is primarily concerned with what happens in a dental appointment. The public talked about safety in terms of knowing the treatment risks and being in 'safe hands' (2,4). In contrast, dental groups presented complaints as a serious issue facing every dentist and talked about 'defensive dentistry' and a 'climate of fear' (2,4).*

### General Communication

*Communication was widely discussed in all focus groups. Good communication was considered a very important aspect of professionalism. Empathy, compassion, politeness and friendliness helped patients to feel treated as persons and making conversation was seen as instrumental in putting patients at ease.*

*Poor communication was described as unclear, robotic, rude, condescending, rushed, overly familiar, non-existent, or not respecting privacy (2). The importance of dentists building rapport and trust with patients was discussed. The public and professionals shared the view that dentists should be formal with patients, at first, but may become more informal over time (2). Interactions with patients were discussed almost twice as frequently as interactions with other members of the team by scoping interview participants (2).*

Patients expect to be treated with dignity, respect and compassion. These expectations are important to patients because a caring manner and good communication can lessen patient anxiety and enhance patients' assessment of the quality of the care.

### Explaining treatment

Patients expect technically good care and on balance, this appears to be more important to them than other aspects of professional behaviours.

*It was also highlighted that patients want clear explanations of treatment options without being overwhelmed (2). For parents, the experience of taking their children to the dentist was very important in forming their opinion of dental professionals.*

Dental professionals are expected to be trained to provide dentistry and to be up to date. Patients expect to have their interests put first and to be involved in decision-making about their treatment and care. Involvement in decision-making helps to develop trust.

#### Premises and Appearances

*The members of the public were concerned about practice and practitioner hygiene and cleanliness (2). They wanted clean surgeries and were deterred by mouldy premises, old houses and back streets, and a lack of privacy (2).*

*Appearance and clothing were discussed more in the dental groups than the public groups. Dental professionals agreed that appearance matters to patients and thought that wearing a uniform, for example, creates a good impression and recognised a shift in the perception of tattoos, piercings, and brightly coloured hair, with attitudes becoming more accepting (2). The patients were vaguer about their expectations, wanting a dentist to look smart, groomed, and clean (2).*

#### Out of work behaviour

*The dental groups were more concerned about behaviour outside of the workplace than the public. Drinking alcohol was generally seen as less acceptable for dentists than some other professional groups, for example lawyers. No one suggested that dental professionals should be teetotal, but there was a clear sense of the need for care (for example, avoiding excessive drinking in public and confining drinking to weekends) (2). In contrast, drugs taking was more clearly unprofessional because of its illegal status (2). Dentists also seemed more concerned about interactions with members of the public outside of the workplace (2).*

*Social media was primarily discussed as risky space where inappropriate behaviours may be revealed to patients (2).*

#### Challenges

From our analysis of the literature we noted barriers to professionalism in operation at micro, meso and macro levels in a complex mix. Working in the best interests of patient may be challenging because of financial disincentives and pressures, unrealistic patient expectations and working environments.

The public expects a consumer service from dental professionals and the dental team that is part of the service. The financial and transactional elements of dental care influence patient experience, access to care and trust. *In the scoping interviews some interviewees noted that there can be a tension patient interests and financial interests (2). Dental groups implied that they work in the patients' best interests but are nevertheless seen by some as focused on the business aspect of practice because of a small minority of dentists who prioritise profit (2). Members of the public were indeed concerned with dentists working for profit, although they did not report any stories which directly supported this (2).*

*The dental focus groups shared potential communication challenges, for example, managing the anxious patient or a confrontational patient (2). Demand for cosmetic treatments (e.g. Botox) was noted as becoming more common, which has implications for the nature of communications between professionals and patient (2).*

The quality of communication can be limited by time-constraints and patient requirements.

***Dental groups discussed the impact of regulations, financial pressures, and isolation on professionalism. (2)***

Research Question 2: How can aspects of professionalism be categorised?

Categorisations of professionalism were not often explicit in the literature. From our analysis of the literature, we identify three key areas of professionalism.

1. Expected service experience which would include:
  - What is expected from the members of the dental team (and their roles)
  - Safe and clean practice
  - Timeliness of services (getting appointments and being seen on time)
2. Interpersonal patient experiences which focusses on the patient experience of interactions with dental professionals:
  - Communication skills, including listening, empathy, trustworthiness, conveying a sense of being treated with dignity and respect
  - Being empowered and involved as a partner in making decisions about their own care
  - Feeling that decisions are financially fair and are based on their own needs and not financial pressures on the dentist
  - Being able to understand proposed treatment and the costs of dental care
3. Professionalism in dentistry and the personal and professional divide
  - Expectations of a dental professional and their behaviour in their personal life (being someone who can be trusted to make an appropriate decision)

From the Delphi survey, some aspects of professionalism appear to be well defined and clear-cut, such as not discriminating against patients or making sexual advances to patients in the workplace. The importance of gaining consent from patients, communicating effectively and making care decisions based on the patient's best interest was also evident from our results. Other aspects are less clear, for example, the appearance and presentation of registrants and where their professional life and personal life begins and ends.

What is apparent is that many situations are not standardised and are largely contextual. Professionalism is a multifaceted construct and whether an action or behaviour is considered to be unprofessional will depend on a number of different aspects: inter-alia, cultural or religious factors, environment and setting, the observer or individual the action is directed towards and their perception, and whether the scenario was a one-off event or a patterned behaviour.

*Distinction was made between behaviour inside and outside of the workplace. Members of the public were much less concerned than the dental team members about behaviour outside the workplace. Ethics were discussed in the public groups only in relation to specific examples of morally questionable behaviour provided by group members (1). To an extent, professionalism was seen as extending beyond what happens in the clinic:*

some interview participants expected professionals to behave in an ethical fashion even when it has no impact on patients (1).

***For many in the dental groups, clinical competence was an assumed aspect of professionalism (1).*** Clinical competence was discussed less frequently, in the scoping interviews, than in relation to preparedness for practice. One interviewee explained that they viewed clinical competence as a prerequisite for professionalism.

Often scoping interview participants found it easier to define professionalism by discussing lapses in professionalism. In most cases breaches in professionalism were framed as 'lapses', meaning that behaviour in a particular situation may be unprofessional without implying that person is inherently unprofessional. There was a recognition that everyone makes mistakes, and that the important thing is to learn from them (1,4).

Research Question 3: Do expectations of professionalism differ in dentistry compared to other professions or between dental professionals

Expectations between different dental professionals:

***There was some disagreement, across the focus groups, on whether DCPs should meet the same standards of professionalism as dentists. Some argued that lower standards of professionalism should apply to dental nurses; others that standards should be applied equally across the team. While the dental groups discussed the roles of DCPs, patients focused on the importance of the role of the receptionist as their first point of contact.***

When comparing the views among different groups from the survey responses (namely dentists, DCPs and members of the public), it was evident that generally, DCPs appear to be the most vigilant or stringent around aspects of professionalism. For the majority of items, DCPs more often rated behaviours or attributes towards the extreme ends: highly unprofessional or essential. Dentists on the other hand appeared to be the most tolerant or lenient towards certain behaviours, with more inclination towards not unprofessional or moderately unprofessional, or not necessary or, desirable. The public was subsequently positioned somewhere between the two.

When considering their own professionalism, we deem it important for registrants to acknowledge the views of the public reported here and understand their priorities as a patient.

Expectations of dentists compared with other professions

The literature suggests that many aspects of professionalism are similar to other healthcare professions. The most marked differences appear to lie in the transactional, financial and contractual areas of practice. The costs associated with dentistry influence how this is viewed, which may explain why patients express their views of dentistry in similar terms to those of other transactional consumer services. The financial and wider pressures on decisions are identified as a concern for patients and a source of stress and challenge for dentists. We also note that the wider healthcare literature gives more attention to reporting research on clinician burnout than the dentistry literature.

***Participants, in the focus groups, made comparisons with healthcare and other professions. Overall, both dental and public groups noted that professionalism is very***

*similar in dentistry and medical professions (and other professions, such as teaching) that require public trust. The general opinion expressed, by scoping interview participants, was expectations around professional behaviour were similar across different healthcare professions, but professionalism is culturally and context specific.*

Research Question 4: Teaching professionalism – how does the undergraduate curriculum prepare students to meet professionalism expectations and how this is evidenced?

Although formal curricula for professionalism have been defined, teaching and assessing professionalism is recognised as complex. Alongside the formal curriculum, mentoring and reflective practice, role modelling and the hidden curriculum play a notable part in professionalism development. No one approach is considered to be the most effective or successful for teaching professionalism and multiple approaches are encouraged.

*Insight and reflection were viewed as important throughout dental training and professional practice. All dentist groups noted how new dentists learn from observing seniors, picking up good and bad habits equally easily. It was suggested that professionalism develops in challenging situations.*

*There were discussions about whether and how communication skills can be learned. Some dental professionals thought that communication skills are innate, but others discussed the value of education and training. The public were not knowledgeable about whether dental professionals received formal communication training but thought they should do (1).*

#### Generational and cultural differences

Students appear to feel that professionalism topics are well covered in the undergraduate curriculum. Applying social media guidelines and determining personal from professional behaviour is a specific area identified for additional support. Qualified dentists identify more gaps in their teaching, possibly as undergraduates are often protected from many real-world issues in their teaching. In addition, they prioritise clinical competence and do not engage as much with ‘non-clinical’ topics.

*The dental groups talked about different generations of dentists, noting differences in training, attitudes to social media, communication skills, and attitudes to self-presentation (1,2).*

*To ensure appropriate interactions, dentists were seen as needing to be aware of cultural differences and changes (1,2).*

#### Assessment

Assessing professionalism is challenging and the use of multiple methods and toolkits is encouraged for evidencing professional development, including workplace-based assessments and measures that are longitudinal and provide a better view of professionalism. Feedback and reflection can strengthen the value of assessment.

*The thematic analysis suggests that professionalism is developed through observation and reflection and can be challenging to assess.*

#### Teamwork and associated barrier and challenges

*In the dental focus groups, there were discussions about working together as a team and joint responsibility in delivering good care.*

*Challenges to professionalism were noted in dental groups including calling out the unprofessional behaviours of others, seeing a wide range of patients and fulfilling everyone's expectations, patients insisting on inappropriate cosmetic treatment and navigating social media (1,2).*

## Conclusions and Implications

This section draws on the wealth of evidence collected to consider the implications of the research

### *Research Question 1: Public Expectations of Professionalism*

#### **Implications**

- 1.1 Further research is needed on:
  - a. professionalism beyond the individual, attending to the influence of the dental team, organisations and the NHS system;
  - b. the penalties associated with lapses in professionalism or criminal conviction and what would be appropriate within specific contexts;
  - c. approaches to addressing lapses in professionalism, for example the role of remediation;
  - d. the interface between the law and dentistry and approaches for managing these pressures on professional practice (often leading to the perception of 'defensive dentistry');
  - e. exploring concepts of seriousness in terms of lapses of professional behaviours and how these are mitigated or addressed.
- 1.2 Members of the public could benefit with being better informed about the financial and business constraints of running a general dental practice and the equipment and technical expenses that are incurred. This may help them to understand the balance of factors that impact on their individual dental care.

### *Research Question 2: Categorisations of Professionalism*

#### **Implications**

- 2.1 Serious unprofessional behaviour worthy of a fitness to practise investigation needs to be distinguished from a less serious lapse in professionalism. A lapse in professionalism may not imply persistent unprofessional actions and remedial action can focus on learning from the mistake.
- 2.2 There is a need for better clarity in terms of *how* professional or unprofessional a behaviour is. There are considerable anxieties amongst the dental profession particularly in relation to payments and systemic pressures on practice and there is little information to indicate how this should be overcome particularly as the evidence often centres on the individual and not on the system.

### *Research Question 3: Expectations of professionalism for different dental professionals and, in comparison with other professions*

#### **Implications**

- 3.1 There is a need for all dental professionals to work together as a team as they have a joint responsibility to deliver the appropriate oral healthcare to patients in a professional manner.

#### *Research Question 4: Teaching and evidencing professionalism*

##### **Implications**

- 4.1 Managing the anxious patient and confrontational situations are areas for strengthening throughout the continuum of dental education and training for the whole dental team (including receptionists).
- 4.2 Professionalism teaching should reflect a variety of changing contexts that challenge professionals in the 21<sup>st</sup> century. Up to date examples of guidance and support structures should be in place for professionals and the public, and regularly updated.
- 4.3 Whilst some professionals welcome 'direction', there is a need to instil a positive ethos of professionalism in students and established professionals. It might be useful, when students first learn about professionalism to adopt a positive approach of professionalism, as viewed by the profession, and address the issues of regulation and FtP once that positive ethos is imbedded.
- 4.4 There is a need to overturn the present reported 'fear factor' and 'blame culture' that can easily lead to 'defensive' dentistry. In so doing, the objective must be to focus on providing the right care, at the right time, provided by the right person to promote prudent and appropriate healthcare provision (Bevan Commission 2015) for all members of the public and instil pride in what dental professionals do.
- 4.5 Consistency in approach and engagement were key messages for lifelong learning. This might be promoted through:
  - a. working with education providers across the student/graduate transition.
  - b. promoting reflective practice, peer discussion and interprofessional reviews via shared learning and experience for students/trainees (possible 'shadowing' opportunities) for early stage career posts.
- 4.6 Further research is needed on:
  - a. using positive concepts of professionalism in teaching
  - b. how technology and social media can and should be used
  - c. Approaches to address the conflict between the teaching of positive and supportive approaches to professionalism and the influence of concerns about fitness to practise in shaping student and trainee attitudes and understanding.



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## Appendices

### Appendix 1: Expert Reference Group membership

We are extremely grateful to colleagues who agreed to be members of our Expert Reference Group, namely:

James Ashworth-Holland, Jimmy Boyle, Alice Duke, Paul Knott, Susie Sanderson, Nishma Sharma, Sandra Zijlstra-Shaw

## Appendix 2: Scoping Interviews: Information Sheet and Consent Form

### Professionalism in Dentistry

#### PARTICIPANT INFORMATION SHEET

You are invited to take part in a study of professionalism in dentistry. Before you decide whether or not to take part, please read the following information carefully. If you have any questions, please contact Alison Bullock whose contact details are provided at the end.

#### **What is the purpose of the research?**

Our aim is to explore and seek consensus on what 'professionalism' means to dental professionals and the general public, why it is important and how undergraduate education can prepare dental students to meet professionalism expectations.

#### **Who is organising and funding this research?**

The study is commissioned and funded by the General Dental Council (GDC). It is co-led by Professor Alan Gilmour and Professor Jonathan Cowpe based in the School of Dentistry and Professor Alison Bullock, School of Social Sciences at Cardiff University.

#### **Why have I been invited to take part in the study?**

You have been invited to participate due to your knowledge and experience in the field of dentistry and professionalism.

#### **Do I have to take part in the study?**

No, your participation is entirely voluntary. If you *do* decide to participate in the study, we will ask you to sign a consent form. You will be free to withdraw from participation at any time, without giving reason and any data previously collected from you will not be included in the study. If you decide you *do not* wish to participate, you do not have to provide a reason.

#### **What will taking part involve?**

Taking part in the study will involve participating in either a face-to-face or telephone interview where you will be asked about your views on dental graduates' professionalism. You are not expected to provide any information or opinion which you do not feel comfortable sharing. Should you provide permission freely, the interview discussion will be recorded for later transcription at which point all data will be anonymised.

#### **Will I be paid anything for taking part?**

No, there are no payments for taking part in this study.

#### **What are the possible benefits of taking part?**

Your participation in this study will involve sharing your views on what is meant by 'professionalism' in dentistry and what would constitute a breach in professionalism. Although there are no direct benefits to you as a result of your participation, this information will be used to help understand how different stakeholders perceive professionalism in dentistry and what is deemed to be important. This can inform recommendations to relevant stakeholders.

#### **What are the possible risks of taking part?**

The only foreseeable potential risk of participation in this study is some discomfort you may feel in sharing your views on professionalism in dentistry. It is not our intent to cause discomfort and you are encouraged to only contribute opinions you feel comfortable sharing.

**Will my taking part in this study be kept confidential?**

All data that you provide in face-to-face or telephone interviews will be anonymised on transcription. Data collected from you during the study will be kept strictly confidential and any personal information you provide will be managed in accordance with data protection legislation.

**What will happen to my personal data?**

The only personally identifiable data collected from you and retained will be your consent form (should you provide it), which will include your name and signature. This information is only collected so we know who has consented to participate in the study. All information provided by you will be anonymous and will not be matched to the information in your consent form. Your consent form will be retained in accordance with Cardiff University research ethics requirements and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised data will be kept for a minimum of 5 years, or at least 2 years post-publication. Although this research study is funded by the GDC, no raw data will be shared with them.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University Data Protection Officer can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection can be found at:

<https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

In providing data for this research, we will process it on the basis that it is part of our public task as a university established to advance knowledge and education through its teaching and research activities.

**What will happen to the results of the study?**

The principal output of the study will be a report documenting findings about dental professionals' and the public's views on professionalism, what is deemed to be important and what is considered to be a breach in professionalism. This report will be shared with GDC. However, they will not have access to your personal data and will only see the anonymised report. It is expected that this report will be available in February 2020, though this is subject to change.

It is also our intention to report the results in academic journals and at relevant conferences. All data will remain anonymous and participants will not be personally identified in any report, publication or presentation.

**What if there is a problem?**

Research team members, Alison Bullock, Alan Gilmour and Jonathan Cowpe will be available to answer any questions or queries regarding any aspects of the research study. If you wish to complain or have concerns about the way you have been approached or treated during the course of this study, please contact the research ethics committee at [socsi-ethics@cardiff.ac.uk](mailto:socsi-ethics@cardiff.ac.uk).

**Who has reviewed this study?**

This study has been reviewed and given a favourable opinion by the School of Social Sciences' Research Ethics Committee at Cardiff University.

**Further information and contact details**

Should you have any questions or queries relating to this study, please contact:

Alison Bullock Telephone: 02920 870780 Email: [bullockad@cardiff.ac.uk](mailto:bullockad@cardiff.ac.uk)

Cardiff University School of Social Sciences, 12 Museum Place, Cardiff, CF10 3BG

**Thank you for considering participation in this study.**

## PARTICIPANT CONSENT FORM

Title of study: **Professionalism in Dentistry & Preparedness-for-Practice**

Name of Researcher: **Professor Alison Bullock**

Please initial  
box

I confirm that I have read and understood the Information Sheet dated 13 August 2019 Version 2 for the above study and have had the opportunity to ask questions and these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw from the study at any time without giving a reason and without any adverse consequences.	
I consent to the processing of my personal data provided on this consent form. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information I provide, how the data will be stored and what will happen to the data at the end of the project.	
I understand that the interview discussion will be audio recorded and that anonymised excerpts and/or verbatim quotes from my interview may be used as part of the research report.	
I understand how the findings and results of this study will be written up and disseminated.	
I give consent freely to my participation in this study.	

\_\_\_\_\_  
Name of participant (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Alison Bullock

\_\_\_\_\_  
Name of person taking consent  
(print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**THANK YOU FOR PARTICIPATING IN OUR RESEARCH.**

## Appendix 3: Focus Groups: Information Sheet and Consent Forms

### Professionalism in Dentistry

#### PARTICIPANT INFORMATION SHEET: Public

You are invited to take part in a study of professionalism in dentistry. Before you decide whether or not to take part, please read the following information carefully. If you have any questions, please contact Alison Bullock whose contact details are provided at the end.

#### **What is the purpose of the research?**

The aim of this research is to explore and seek consensus on what 'professionalism' means to dental professionals and the general public, why it is important and how undergraduate education can prepare dental students to meet professionalism expectations.

#### **Who is organising and funding this research?**

The study is commissioned and funded by the General Dental Council (GDC). It is co-led by Professor Alan Gilmour and Professor Jonathan Cowpe based in the School of Dentistry and Professor Alison Bullock, School of Social Sciences at Cardiff University.

#### **Why have I been invited to take part in the study?**

You have been invited to participate due to your involvement in an existing group set up by the GDC.

#### **Do I have to take part in the study?**

No, your participation is entirely voluntary. If you *do* decide to participate in the study, we will ask you to sign a consent form. You will be free to withdraw from participation in the study at any time, without giving reason and any data previously collected from you will not be included in the study.

If you decide you *do not* wish to participate, you do not have to provide a reason.

#### **What will taking part involve?**

Taking part in the study will involve participating in a focus group with other members of the public. Here you will be asked about your views on what is meant by 'professionalism' in dentistry, what you deem to be important and what you consider to be a breach in professionalism. You are not expected to provide any information or opinion which you do not feel comfortable sharing.

Should you provide permission freely, the focus group discussion will be recorded for later transcription at which point all data will be anonymised. If you agree to participate in the focus group but do not give permission for recording, any input you provide will not be transcribed for data analysis.

#### **Will I be paid anything for taking part?**

There are no payments for your time in taking part in this study. However, you will be offered a £20 voucher as a thank you for participating.

#### **What are the possible benefits of taking part?**

Your participation in this study will involve sharing your views on professionalism in dentistry. Although there are no direct benefits to you as a result of your participation, this information will be used to help understand how different stakeholders perceive professionalism in dentistry and what is deemed to be important. This can inform recommendations to relevant stakeholders.

**What are the possible risks of taking part?**

The only foreseeable potential risk of participation in this study is some discomfort you may feel in sharing your views on professionalism in dentistry in the presence of other focus group participants. It is not our intent to cause discomfort and you are encouraged to only contribute opinions you feel comfortable sharing.

**Will my taking part in this study be kept confidential?**

Should you grant permission for the focus group discussion to be recorded, all data provided by you and your fellow participants will be anonymised on transcription and you will not be personally identifiable. However, you should understand the limits in confidentiality of focus group discussions in that any information you share will be known to other focus group participants. All focus group participants will be asked to respect the confidentiality of the discussion. Data collected during the study will be kept strictly confidential and any personal information you provide will be managed in accordance with data protection legislation.

**What will happen to my personal data?**

The only personally identifiable data collected from you and retained will be your consent form (should you provide it), which will include your name and signature. This information is only collected so we know who has consented to participate in the study. All information provided by you will be anonymous and will not be matched to the information in your consent form. Your consent form will be retained in accordance with Cardiff University research ethics requirements and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised data will be kept for a minimum of 5 years, or at least 2 years post-publication. Although this research study is funded by the GDC, no raw data will be shared with them.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University Data Protection Officer can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection can be found at:

<https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

In providing data for this research, we will process it on the basis that it is part of our public task as a university established to advance knowledge and education through its teaching and research activities.

**What will happen to the results of the study?**

The principal output of the study will be a report documenting findings about dental professionals' and the public's views on professionalism, what is deemed to be important and what is considered to be a breach in professionalism. This report will be shared with GDC. However, they will not have access to your personal data and will only see the anonymised report. It is expected that this report will be available in February 2020, though this is subject to change.

It is also our intention to report the results in academic journals and at relevant conferences. All data will remain anonymous and participants will not be personally identified in any report, publication or presentation.

**What if there is a problem?**

Research team members, Alison Bullock, Alan Gilmour and Jonathan Cowpe will be available to answer any questions or queries regarding any aspects of the research study. If you wish to complain or have concerns about the way you have been

approached or treated during the course of this study, please contact the research ethics committee at [socsi-ethics@cardiff.ac.uk](mailto:socsi-ethics@cardiff.ac.uk).

**Who has reviewed this study?**

This study has been reviewed and given a favourable opinion by the School of Social Sciences' Research Ethics Committee at Cardiff University.

**Further information and contact details**

Should you have any questions or queries relating to this study, please contact:

Alison Bullock Telephone: 02920 870780 Email: [bullockad@cardiff.ac.uk](mailto:bullockad@cardiff.ac.uk)

Cardiff University School of Social Sciences, 12 Museum Place, Cardiff, CF10 3BG

**Thank you for considering participation in this study.**

# Professionalism in Dentistry

## PARTICIPANT INFORMATION SHEET: Dental Professionals

You are invited to take part in a study of professionalism in dentistry. Before you decide whether or not to take part, please read the following information carefully. If you have any questions, please contact Alison Bullock whose contact details are provided at the end.

### **What is the purpose of the research?**

The aim of this research is to explore and seek consensus on what 'professionalism' means to dental professionals and the general public, why it is important and how undergraduate education can prepare dental students to meet professionalism expectations.

### **Who is organising and funding this research?**

The study is commissioned and funded by the General Dental Council (GDC). It is co-led by Professor Alan Gilmour and Professor Jonathan Cowpe based in the School of Dentistry and Professor Alison Bullock, School of Social Sciences at Cardiff University.

### **Why have I been invited to take part in the study?**

You have been invited to participate due to your experience as a dental professional.

### **Do I have to take part in the study?**

No, your participation is entirely voluntary. If you *do* decide to participate in the study, we will ask you to sign a consent form. You will be free to withdraw from participation in the study at any time, without giving reason and any data previously collected from you will not be included in the study.

If you decide you *do not* wish to participate, you do not have to provide a reason.

### **What will taking part involve?**

Taking part in the study will involve participating in a focus group with other dental professionals. Here you will be asked about your views on what is meant by 'professionalism' in dentistry, what you deem to be important and what you consider to be a breach in professionalism. You are not expected to provide any information or opinion which you do not feel comfortable sharing.

Should you provide permission freely, the focus group discussion will be recorded for later transcription at which point all data will be anonymised. If you agree to participate in the focus group but do not give permission for recording, any input you provide will not be transcribed for data analysis.

### **Will I be paid anything for taking part?**

No, there are no payments for taking part in this study.

### **What are the possible benefits of taking part?**

Your participation in this study will involve sharing your views on professionalism in dentistry. Although there are no direct benefits to you as a result of your participation, this information will be used to help understand how different stakeholders perceive professionalism in dentistry and what is deemed to be important. This can inform recommendations to relevant stakeholders.

### **What are the possible risks of taking part?**

The only foreseeable potential risk of participation in this study is some discomfort you may feel in sharing your views on professionalism in dentistry in the presence of other focus group participants. It is not our intent to cause discomfort and you are encouraged to only contribute opinions you feel comfortable sharing.



**Will my taking part in this study be kept confidential?**

Should you grant permission for the focus group discussion to be recorded, all data provided by you and your fellow participants will be anonymised on transcription and you will not be personally identifiable. However, you should understand the limits in confidentiality of focus group discussions in that any information you share will be known to other focus group participants. All focus group participants will be asked to respect the confidentiality of the discussion. Data collected during the study will be kept strictly confidential and any personal information you provide will be managed in accordance with data protection legislation.

**What will happen to my personal data?**

The only personally identifiable data collected from you and retained will be your consent form (should you provide it), which will include your name and signature. This information is only collected so we know who has consented to participate in the study. All information provided by you will be anonymous and will not be matched to the information in your consent form. Your consent form will be retained in accordance with Cardiff University research ethics requirements and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised data will be kept for a minimum of 5 years, or at least 2 years post-publication. Although this research study is funded by the GDC, no raw data will be shared with them.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University Data Protection Officer can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection can be found at: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

In providing data for this research, we will process it on the basis that it is part of our public task as a university established to advance knowledge and education through its teaching and research activities.

**What will happen to the results of the study?**

The principal output of the study will be a report documenting findings around dental professionals' and the public's views on professionalism, what is deemed to be important and what is considered to be a breach in professionalism. This report will be shared with GDC. However, they will not have access to your personal data and will only see the anonymised report. It is expected that this report will be available in February 2020, though this is subject to change. It is also our intention to report the results in academic journals and at relevant conferences. All data will remain anonymous and participants will not be personally identified in any report, publication or presentation.

**What if there is a problem?**

Research team members, Alison Bullock, Alan Gilmour and Jonathan Cowpe will be available to answer any questions or queries regarding any aspects of the research study. If you wish to complain or have concerns about the way you have been approached or treated during the course of this study, please contact the research ethics committee at [socsi-ethics@cardiff.ac.uk](mailto:socsi-ethics@cardiff.ac.uk).

**Who has reviewed this study?**

This study has been reviewed and given a favourable opinion by the School of Social Sciences' Research Ethics Committee at Cardiff University.

**Further information and contact details**

Should you have any questions or queries relating to this study, please contact:  
Alison Bullock Telephone: 02920 870780 Email: [bullockad@cardiff.ac.uk](mailto:bullockad@cardiff.ac.uk)  
Cardiff University School of Social Sciences, 12 Museum Place, Cardiff, CF10 3BG

**Thank you for considering participation in this study.**

## PARTICIPANT CONSENT FORM: Member of the Public

Title of study: **Professionalism in Dentistry**

Name of Researcher: **Professor Alison Bullock**

Please initial  
box

I confirm that I have read and understood the <b>PARTICIPANT INFORMATION SHEET: Public</b> and have had the opportunity to ask questions and these have been answered satisfactorily. <b>I have been given a copy of this sheet to takeaway.</b>	
I understand that my participation is voluntary, and I am free to withdraw the study at any time without giving a reason and without any adverse consequences.	
I consent to the processing of my personal data provided in this consent form. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information I provide, how the data will be stored and what will happen to the data at the end of the project.	
I understand that the focus group discussion will be audio recorded and that anonymised excerpts and/or verbatim quotes from my focus group may be used as part of the research report.	
I understand how the findings and results of this study will be written up and disseminated.	
I give consent freely to my participation in this study.	

\_\_\_\_\_  
Name of participant (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent  
(print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**THANK YOU FOR PARTICIPATING IN OUR RESEARCH.**

## PARTICIPANT CONSENT FORM: Dental Professionals

Title of study: **Professionalism in Dentistry**

Name of Researcher: **Professor Alison Bullock**

Please initial  
box

I confirm that I have read and understood the Information Sheet dated 12 August 2019 Version 1 for the above study and have had the opportunity to ask questions and these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw the study at any time without giving a reason and without any adverse consequences.	
I consent to the processing of my personal data provided in this consent form. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information I provide, how the data will be stored and what will happen to the data at the end of the project.	
I understand that the focus group discussion will be audio recorded and that anonymised excerpts and/or verbatim quotes from my focus group may be used as part of the research report.	
I understand how the findings and results of this study will be written up and disseminated.	
I give consent freely to my participation in this study.	

\_\_\_\_\_  
Name of participant (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent  
(print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**THANK YOU FOR PARTICIPATING IN OUR RESEARCH.**

## Appendix 4: CPD Feedback Form for Dental Professionals take part in a Focus Group

Feedback for the Focus Group Meeting for dental professionals on the subject of 'Professionalism'

**Aims of the focus group discussions:** Research shows that a high standard of 'professionalism' is important to patients, dental professionals and to dental professional regulators. This focus group discussion session aims to promote innovative and constructive debate on a series of issues contributing to a high standard of 'professionalism' in the dental and the wider healthcare sectors. Discussions will contribute to a Rapid Evidence Assessment project (2019-20) on 'professionalism' and 'preparedness-for-practice' of the new graduate, being undertaken by an ADEE project team, commissioned by the General Dental Council (GDC).

**Objectives of the focus group discussions:**

1. seek to identify what professionalism means and what are considered, by patients and dental professionals, to be lapses in professionalism by dental team members
2. how educational methods are aspiring to address these at both the undergraduate level and the continuing education of dental professionals and identify areas of best practice .
3. explore what aspects of professionalism the public expects (and what causes a patient to lose trust), and why these are perceived as important;

**Learning Outcomes:**

*Please rate the extent to which the session achieved its learning outcomes, using the 0-4 scale (where 0 is 'not achieved', 2 is 'achieved' and 4 'achieved beyond expectations')*

<b><i>Participants will be able to:</i></b>	<b><i>Please insert score from 0-4</i></b>
<b>1. Describe the features behaviours and characteristics of 'professionalism' in dentistry</b>	
<b>2. Discuss what patients consider to be 'professional lapses' by healthcare professionals and what matters most</b>	
<b>3. Debate the emerging challenges to the maintenance of a high standard of 'professionalism'</b>	
<b>4. Describe areas of best practice and innovation in the teaching of 'professionalism' across the continuum of education</b>	

**Additional Feedback or Comments:**

*If you are happy to be contacted further regarding this project please add your contact details.*

## What does professionalism mean for members of the dental team?

### Introduction and consent

Please read this information carefully before deciding whether to participate. If you decide not to take part, there will be no disadvantage of any kind and we thank you for considering our request.

The primary aim of the study, funded by the General Dental Council, is to identify the boundaries of professional behaviour for dental professionals. As well as dentists, members of the dental team include, for example, dental nurses, hygienists, therapists and technicians.

The work is being undertaken by the Association for Dental Education in Europe and this survey is being run by Cardiff University.

We are looking for responses from a wide range of groups including dental professionals, dental educators, and the general public **based in the UK**.

This study uses established research methods to find areas of agreement amongst participants. If you take part you will be asked to respond to two or three rounds of this survey.

During the first round you will be given a range of statements to look at and you will be asked to rate whether or not you feel this behaviour is professional. You will also be invited to add free comments.

In the next round you will be asked only to look at those statements where there wasn't agreement. We will present you with an anonymous summary of the responses from all respondents and you will be invited to reassess your answers and respond again.

We will need to be able to send you an email invitation for each round and you **will be asked to supply an email contact to ensure that we only invite the original participants to respond**. Be assured that only the Cardiff University research team will have access to your email and individual responses.

The survey will take around 10 minutes to complete.

**Participation is voluntary and all data will be held confidentially.** You may withdraw from participation at any point. \* *Required*

- ☐ I am based in the UK and consent to take part in this study. I understand my data will be held securely and I have a right to withdraw from this study at any time.

## Personal Details

Please supply a valid email in order to receive feedback and participate in the next round: \*  
*Required*

Please confirm your email: \* *Required*

Gender:

- ☐ Female
- ☐ Male
- ☐ Prefer not to say
- ☐ Other

Age group:

- ☐ 18-24 years old
- ☐ 25-34 years old
- ☐ 35-44 years old
- ☐ 45-54 years old
- ☐ 55 – 64 years old
- ☐ 65 or over

Your role: *(tick all that apply)*

- ☐ Member of the public
- ☐ Dentist
- ☐ Dental Care Professional
- ☐ Dental educator or trainer
- ☐ Dental student
- ☐ Policy maker or regulator
- ☐ Other

# What does professionalism mean for members of the dental team?

## How unprofessional?

We present statements related to the behaviours and attributes of dental professionals in two sections. In this, the first section, for each item listed we ask you to indicate the extent to which the behaviour or attribute is unprofessional.

**Workplace behaviour.** Please choose one option for each of the items below to indicate the extent to which each behaviour or attribute is unprofessional:

Please don't select more than 1 answer(s) per row.

	Not unprofessional	Moderately unprofessional	Highly unprofessional
Discriminating against patients on the basis of race, religion, disability, gender, sexuality, age etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking about their own personal life with colleagues in the workplace within earshot of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cursing and swearing in the workplace within earshot of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having visible tattoos or facial piercings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking during the work day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepting freebies for promoting dental products to patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making sexual advances to a patient in the workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing non-essential antibiotics at a patient's request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Berating a patient for not following oral health advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking about a patient's dental or medical care to co-workers not directly involved in the patient's care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discussing with a patient their medical or dental care in the presence of other patients (i.e. in the reception area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Public behaviours (ie those that might be witnessed by members of the public).** *Please choose one option for each of the items below to indicate the extent to which each behaviour or attribute is unprofessional:*

	Not unprofessional	Moderately unprofessional	Highly unprofessional
Getting drunk in a public bar during the working week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting drunk in a public bar when not working the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking about work on public profiles on social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Publicly liking a racist joke on social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing sexually explicit pictures on a public social media page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being rude in public about dental colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cursing and swearing in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making sexist remarks in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Personal private behaviour (i.e. those that would not typically be witnessed by members of the public).** *Please choose one option for each of the items below to indicate the extent to which each behaviour or attribute is unprofessional:*

	Not unprofessional	Moderately unprofessional	Highly unprofessional
Getting drunk at home when working the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of recreational (illegal) substances when working the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of recreational (illegal) substances when not working the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making sexual advances to a patient outside the workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being severely depressed and not seeing a doctor about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convicted of a drink driving offence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being convicted of tax fraud	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepting 'friend requests' from patients via social media, or sending them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Please add any comments you might have about the extent to which the behaviours or attributes listed on this page are unprofessional or may vary between different members of the dental team:

## Essential, desirable or not necessary?

In this section we present statements related to the behaviours and attributes of dental professionals and ask if the listed behaviours and attributes are not necessary / desirable / essential.

**Interactions with patients.** Please choose one option for each of the items below to indicate whether the behaviour or attribute in a dental professional is not necessary / desirable / essential:

Please don't select more than 1 answer(s) per row.

	Not necessary	Desirable	Essential
Consistently seeing patients on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treating patients as you, or a close family member, would like to be treated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being a good communicator with all types of patients, even "difficult" ones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explaining to the patient what they are doing and the purpose of their treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listening to patients' requests and treatment preferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking care to explain the different treatment options available and gaining consent for the treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fully explaining the cost of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making care decisions on the basis of patient need, not financial reward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping political opinions out of discussions with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Politely but firmly managing a patient who is being abusive to staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Workplace appearance and behaviour.** Please choose one option for each of the items below to indicate whether the behaviour or attribute in a dental professional is not necessary / desirable / essential:

	Not necessary	Desirable	Essential
Having good personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing a dental uniform (e.g. dental tunic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having neat hair and grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having straight, unstained teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being a positive role-model for younger colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treating all members of the dental team with respect at all times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a good knowledge of other dental professionals roles and duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being familiar with the most up-to-date legal requirements for confidentiality and data storage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with accidental breaches of confidentiality immediately and informing the patient(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only using photographs of patients with their permission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing learning from training with colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflecting on their own knowledge and seeking out training to improve it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping up to date through ongoing education and training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

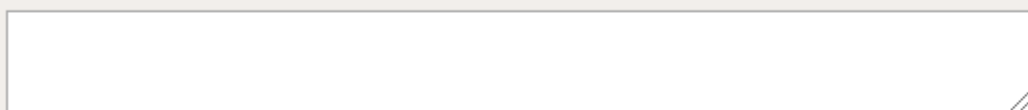
**Public behaviours.** Please choose one option for each of the items below to indicate whether the behaviour or attribute in a dental professional is not necessary / desirable / essential:

	Not necessary	Desirable	Essential
Behaving politely at all times in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

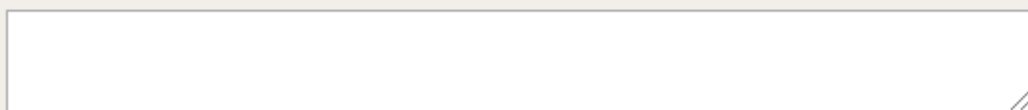
**Personal private behaviour.** Please choose one option for each of the items below to indicate whether the behaviour or attribute in a dental professional is not necessary / desirable / essential:

	Not necessary	Desirable	Essential
Seeing professionalism as a core belief extending beyond the workplace into everyday life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a clean criminal record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please add any comments you might have about whether the behaviours or attributes listed on this page are not necessary, desirable or essential or may vary between different members of the dental team:



Do you have any comments on whether the standards of professionalism expected in dentistry are different from other professions?



## Final page

Thank you for taking part in the first round of this questionnaire.

You will receive an email from us in the week beginning 9<sup>th</sup> Dec with a link to round two of the study. For the second round, you will be invited to reassess your answers (based on the anonymous aggregate results of the first round) for those behaviours and attributes which did not reach agreement. This may continue for a further, third round.

If you have any questions regarding this study please contact Professor Alison Bullock at [bullockad@cardiff.ac.uk](mailto:bullockad@cardiff.ac.uk) or Elaine Russ at [russem@cardiff.ac.uk](mailto:russem@cardiff.ac.uk)

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## Appendix 6: Further information on the *Moving Up Stream* event

Panel 2: Demonstrating commitment to right-touch regulation (RTR). Chair: GDC Council member

The Panel included representation from the Professional Standards Authority - PSA; the General Pharmaceutical Council - GPhC; the General Medical Council - GMC; the Dental Defence Union - DDU.

### PSA

RTR is a tool and a way of thinking. Professions that are highly clinical and require consent are at high risk. What actions lie with the regulators and what with the employers? Was one of the questions raised. Minor lapses should be addressed with local training; criminal lapses (not substance abuse) by courts; regulatory bodies should take a risk-based approach.

### GPhC

GPhC regulates professionals and systems (premises) and asks whether a lapse is due to a professional or a system. This provides a more holistic perspective which allows them to manage risk of harm in the context in which the professional is working. They employ the principles of right touch regulation. They can put restrictions on premises if no improvement within 28 days. - new enforcement policy. Priority inspections have coincidentally led to more enforcement. The GPhC can influence non-pharmacist owners and corporates.

### GMC

The GMC has a priority to protect the public and assess fitness to practise (similar to GDC). There is no simple answer to RTR. The GMC has outreach teams that work with and support employers which helps solve some issues on a more local level. They have a process of filtering complaints, gaining more information initially and working with employers on health issues to avoid further pressure. The GMC is working to better understand local environments. They work with employers and meet doctor groups.

### DDU

Public expectations have changed and the standards for the dental team are prescriptive but there are no supporting toolkits. Risks: *"plants don't thrive if you keep pulling them out of the ground to check the roots are okay"*. The approach in the aviation industry where no one person is blamed, instead they look at the framework of events and a risk matrix in order to prevent a future repeat, was applauded. However, it was noted that aviation is a much less contextualised environment than healthcare. Separating complaints from discipline, should be advocated. There is need to get triage better, not least because an investigation starts the 'sanction process' for the individual, which can in turn seriously impact on patient care if it leads to cancelling patients or interfering with patient care delivery.

### Open Session: Questions and Contributions

Fear factor exists among all registrants. Lawyers advertising for litigation purposes has the potential to enhance the fear factor. Fear of litigation has become worse than fear of regulation. Can the GDC work with lawyers?

Patients need to recognise that often treatment isn't pleasant and also doesn't always work – this does not mean they have experienced bad dentistry or have a claim against the practitioner.

More risk may be associated with relief staff or locums and sole practitioners because of perceived lack of line management and working unsupervised. The question, who owns that person's performance? was raised.

### **Breakout Session: How well does the system in which dental services are provided protect the public?**

What's effective?

- Range of clinical guidelines and services
- Ethical approaches
- Assessment methods
- Lifelong learning
- Existence of registers and regulators
- There are as many as 9 different checks of the systems in place – improve engagement and co-operation.

What's vulnerable?

- Where dentistry – the profession - begins and ends – professional life vs. private life
- Legal framework and dentistry act are outdated
- IT and AI
- Some services are reactive rather than proactive
- Limited support post- foundation training – some may even bypass FT entirely
- Non-UK trained professionals – communication and standardisation
- Practices' priority is to ensure financial stability
- Clinical governance and role of the GDC
- Dental profession carrying out irreversible procedures - need for interaction and communication
- Corporates - young and inexperienced working together - feed off each other's deficiencies- need for senior mentorship
- Joined up actions are important but restricted by regulatory events

Where are the safeguards?

- Patients' charter – what is reasonable to expect?
- Improving risk management in practices
- Update to legislation on how GDC works
- Mentorship
- Extend remit of CQC and HEIW – see patients and day-to-day practice
- Focus on prevention
- Need to be able to empower and learn from lapses and near misses

What can be done?

- Need for early year support and supervision to also strengthen insight
- Teamwork - sharing lapses – with peers or mentors. Consistently working together
- Build on effective 'professional advice support and sharing' (PASS) process - applies to those on the performers list - performance management process
  - Identify and signpost support.

- Remediation: return to work - needs funding.
  - PASS practice visitation, to support all in the team.
- Area teams and GDC investigations need closer cooperation and guidance with a robust structured service level agreement- appropriate approach to FtP issues
- Process to support overseas dentists with identified areas of deficiencies
- Support for associates and for rehabilitation
- Promotion of expertise in practice management